CBCT Referral & Requisition

Clarence Street DENTAL Group

Please send ***completed*** referral form to: lcarver@clarencestreetdental.com or fax to: 519.756.0745

Referring Clinician:

Name:_____

Phone:_____

Email:_____

Patient: Name:_____

Date of Birth:_____

Phone:_____

Email:_____

Delivery Method:

○ Email (free) ○ Mail (+$15)

Field of View:

○ 5x5 ○ 8x8

Resolution:

○ HD on ○ HD off

Region of Interest and Referral Reasons/Details:_____

_____

_____

_____

Signature of Referring Dentist:_____

****Please Be Aware****

- Metallic jewelery, partial dentures and hair clips will need to be removed for the scan.
- These scans will not be covered by your medical insurance as they are not medical scans.
- Dental codes: 07011 or 07012.

Fees: $325

To be paid in full at time of service by debit, cash, visa or mastercard.

519-756-8080 lcarver@clarencestreetdental.com
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