CBCT Requisition

Clarence Street
DENTAL Group

Please email the ***completed*** referral form to info@clarencestreetdental.com or fax it to 519-756-0745.

Referring Clinician: Name: ______________________

Phone: ______________________

Email: ______________________

Patient Details: Name: ______________________

Date of Birth: ______________________

Phone: ______________________

Email: ______________________

Delivery Method: ○ Email

Report: ○ Report only ○ Report and select imaging slices ○ Measurements

Field of View: ○ 5x5 ○ 5x8 ○ 8x8

Resolution: ○ HD on ○ HD off

Region of Interest: ______________________

Reason for Referral: ○ Endodontics ○ Implants ○ Localization of Impacted Teeth

○ Pathological Investigation

Additional Notes: ______________________

____

Signature of Referring Clinician: ______________________

Notes

- Metallic jewelry, partial dentures, and hair clips will need to be removed for the scan.
- These scans are not covered by medical insurance as they are not medical scans.
- The dental codes used are 07011, 07012 , or 07013, and 07031, 07032, and/or 07037.

The fees for this service are $300 - $450, depending on the size of scan. They are to be paid in full at the time of service by debit, cash, Visa, or MasterCard.