CBCT Referral & Requisition

Please send ***completed*** referral form to: clarencestreetdental@gmail.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: ____________________

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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.