Boca
Dental Specialists Group

CBCT Referral & Requisition

Referring Clinician

Referring Dr. *

Office Phone *

Office Email *

example@example.com

Please Note: Metallic jewellery, partial dentures and hair clips will need to be removed for the scan.

For female patients, please advise us if you think you may be pregnant.

Patient

Name *

First Name Last Name

Phone *

Date of Birth *

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Email *

example@example.com

Circle or illustrate the area to be scanned

Tooth Number/s

Indications for Scan

- ☐ Implants / Implant Mapping
- ☐ Salivary Gland
- ☐ Facial/Muscle Pain/Paralysis/Abnormal Sensation
- ☐ Impacted/Delayed/Extra/Malpositioned Teeth
- ☐ Wisdom Teeth
- ☐ Disease/Syndrome/Tumor /TMJ
- ☐ Painful/Cracked/Troublesome Teeth (Endodontic)

Relevant Clinical Details and History