inspire
DENTAL GROUP

Email completed referral form to
downtown@inspiredental.ca

DIAGNOSTIC IMAGE REFERRAL FORM

Patient's Name: ______________________ Appt Date: ______________

Date of Birth: ______________ Telephone: ______________ Appt Time: ______________

Date Report Required: ______________________ ☐ Bill Dr. ☐ Bill Patient

3D CONE BEAM COMPUTED TOMOGRAPHY (CBCT)

FIELD OF VIEW

☐ Single Site (5cm x 5cm) ☐ Single Jaw ☐ Both Jaws

Tooth Number(s): __________ Upper or Lower Jaw: __________

Reason for Scan: ______________________

☐ Implant(s) / Graft ☐ Guided Surgery ☐ Orthodontic ☐ Sinus / Airway ☐ Endodontic ☐ TMJ

☐ Post Op ☐ Pathology

RADIOLOGY REPORT

☐ Radiology Report Not Required

DIGITAL RADIOGRAPHY

Special Instructions / relevant clinical history:

Dr. Name: ______________________ Date: ______________

Dr. Signature: ______________________

Dr. Email: ______________________

VANCOUVER LOCATION

875 West Hastings

Vancouver, BC V6C 3N9

Phone : 604.670.9700

Please click SUBMIT FORM once completed and our team will review and contact you shortly

SUBMIT FORM