iCAT Cone Beam Radiography Referral

ISLAND ORAL FACIAL

AND

IMPLANT SURGERY

Suite 1, 84 Robarts Street, Nanaimo, BC V9R 2S5
Telephone: (250) 753-6671 Fax: (250) 753-8069
Toll Free: 1-866-753-6671

Patient's Name _____ Date of Birth _____
M D Y

Address _____ City _____

Postal Code _____ Referred by Dr. _____

Contact Name: _____ Home Phone: _____ Work: _____

X-rays Enclosed: PAN _____ PA _____ OTHER _____ NONE _____

Dental Insurance:

Plan #1
Name: _____ D.O.B. _____ Plan _____ Gr: _____ ID: _____ Dep _____ % ____

Plan #2
Name: _____ D.O.B. _____ Plan _____ Gr: _____ ID: _____ Dep _____ % ____

Reason for Study/History: _____

_____

_____

Area of Interest: _____

_____

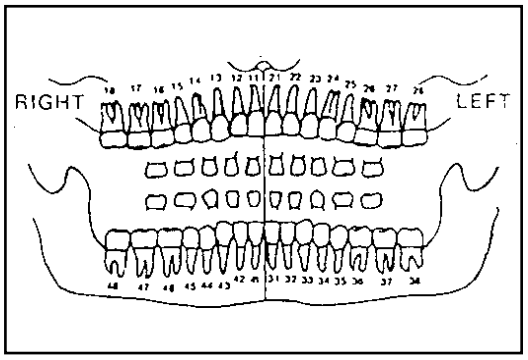
☐ **PANORAMIC VIEW**

☐ **IMPLANT**

☐ **Maxilla**
List area for imaging slices _____

☐ **Mandible**
List area for imaging slices _____

☐ **Combined maxilla/mandible**
List area for imaging slices _____



☐ **Radiographic stent supplied with this referral**

☐ **NobelGuide Protocol** (please ask for protocol sheet to be sent to you)

☐ **TMJ** - Includes bilateral TMJ imaging, sagittal cross sections, coronal view and panoramic image

☐ **Orthodontics** - Includes PA, lateral cephalometrics and panoramic image

Island Oral Facial and Implant Surgery produces these images for your review upon your request. However, the responsibility for diagnosis and management is the responsibility of the referring doctor.