STAMFORD GREEN
DENTAL

CBCT REFERRAL
3D Dental Imaging | For referring dentists

1 PATIENT INFORMATION

Patient full name *

Date of birth (DD/MM/YYYY) *

Patient phone

Patient street address / city *

Postal code

2 REFERRING DENTIST / PRACTICE

Referring dentist name *

Practice / office

Office phone *

Secure contact email *

Office fax (optional)

Referral date *

3 CLINICAL REQUEST / INDICATION

- ☐ Implant planning
- ☐ Impacted tooth
- ☐ Endodontic
- ☐ Surgical planning
- ☐ Lesion / pathology
- ☐ Orthodontic
- ☐ Grafting / site
- ☐ Other

Select region / teeth (FDI numbering):

UPPER	☐ 18	☐ 17	☐ 16	☐ 15	☐ 14	☐ 13	☐ 12	☐ 11	☐ 21	☐ 22	☐ 23	☐ 24	☐ 25	☐ 26	☐ 27	☐ 28
LOWER	☐ 48	☐ 47	☐ 46	☐ 45	☐ 44	☐ 43	☐ 42	☐ 41	☐ 31	☐ 32	☐ 33	☐ 34	☐ 35	☐ 36	☐ 37	☐ 38

Requested scan / site / special instructions (e.g. 35-37, maxilla, limited FOV):

4 CLINICAL HISTORY & REASON FOR CBCT *

Include case history, suspected diagnosis / proposed treatment and the specific clinical question.

Recent radiographs / images of this area:

- ☐ PA
- ☐ Panoramic
- ☐ Bitewings
- ☐ Other
- ☐ Not available

Imaging dates / method of secure transfer (attach relevant images or reports):

5 REPORT / IMAGE DELIVERY

Dentist(s) to receive report / images

Secure delivery contact / instructions

Referral authorized by (print name)

Date

CBCT is performed only if clinically justified by an authorized prescribing dentist.
Please send prior imaging securely. Requested field of view may be adjusted for clinical appropriateness.

3626 Portage Rd, Niagara Falls, ON L2J 2K7 | (905) 356-1623 | Fax: 905-356-9722

stamfordgreendental.com | info@stamfordgreendental.com

Please fax completed form to: 905-356-9722 Or use an approved secure clinical channel.