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London ON, N6H 0H9
Tel. (519) 777-2020
Fax (519) 914-2676
www.albadental.ca
info@albadental.ca

Dental CBCT Scan Referral Form

To make a referral, please remember to complete the fillable form below and save it to your computer before attaching it and sending to Alba Dental Centre by email at info@albadental.ca

**Please note,* if you are using Chrome as your browser, you must click 'print' and then 'save as PDF' before attaching to an email.

If you have any issues entering information and saving the form, please download the PDF and then upload to www.pdfescape.com, you will be then be able to complete the fields and then save the document.

Referring Dentist	Patient Information
Doctor Name: Practice Name: Email: Phone:	Patient Name: Sex: Date of Birth MM/DD/YYYY: Address line 1: Address line 2: City:
RELEVANT XRAYS (PA, BW, PAN) MUST BE INCLUDED FOR ALLPATIENTS, AS PER RCDSO. All metal in the head/neck needs to be removed for the scan.	Province: Postal code: Home phone:
Fees ranges between $225 to $350 To be paid in full at time of service.	Cellphone: Email: Dental History & Medical Alerts:

Indication/s for scan			
Implants	Implant planning	Stent Provided	Measurements
Teeth	Impacted Delayed	Relation to IAN Extra	Painful/cracked/troublesome (Endo) Malpositioned
	Sinuses	TMJ's	Pathology
	Other, please explain: ………………………………………………………………… ………………………………………………………………… …………………………………………………………………		

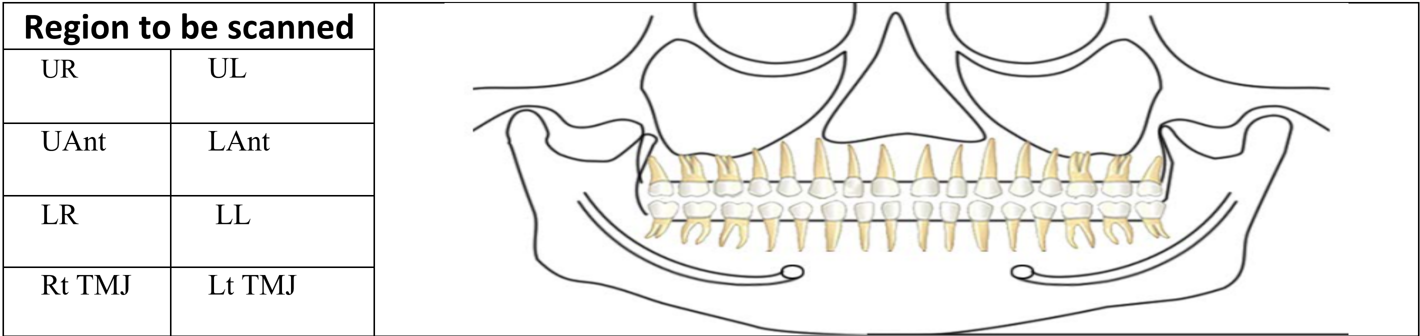
Requested Format of the scan	
DICOM + Viewer	DICOM only (Raw images)

Field of view volume		
5X5	5X8	8X8

Please click or circle the region of interest

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

Region to be scanned	
UR	UL
UAnt	LAnt
LR	LL
Rt TMJ	Lt TMJ



Additional Comments / Clinical Information / Suspected Diagnosis

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Please email the completed form to info@albadental.ca or fax it to (519) 914-2676

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