Kincardine Dentistry CT Referral Form

Name: ______________________________
First Last

DOB: _____/_______/_______ Gender: F / M/ O
DD MM YYYY

Address: ______________________________
Street

____
Town Postal Code

Home Number: ______________________________

Cell Number: ______________________________

Email address: ______________________________

Contact person: ______________________________

Referral Date: ______________________________

Dentist: ______________________________

Office: ______________________________

____
Street Town

____
Postal Code Office number

____
Email

Please provide patient's next appointment:
(If applicable) ______________________________

Cost of scan: $250.00 per view

(Includes: A radiographic report by the oral radiologist)

Circle area of CBCT scan of 5x8cm or less by circling teeth to be included in CBCT

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Date of x-ray: ______________________________

Please check which radiologist

- o Canaray (reading in 100days unless expedited)
- o Orad (reading in 14days(written report only))

Expedite CBCT (please circle)

1-2 Days $115 3-6 Days $75

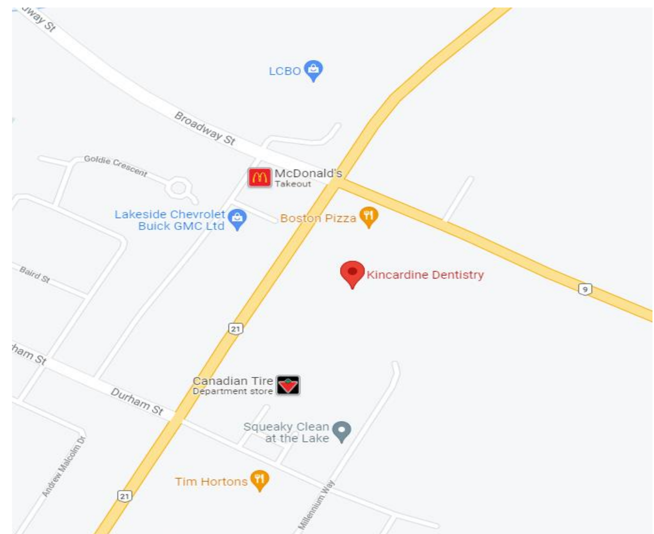
7-12 Days $50 12-17 Days $25

- o Make measurements as well $35

Reason for CBCT (Required be filled out as well as an x-ray)

Please fax or email this completed form, forward x-ray and we will contact the client to arrange appointment.

Kincardine Dentistry



6 Millennium Way Kincardine ON N2Z 0B5
info@kincardinedentistry.com

Fees are due at the end of the appointment. We accept cash, cheque, debit card, Visa and Mastercard. Data and reports will not be released prior to full payment.