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: _____

Office name: _____

_____
Street Town

_____
Postal Code Office number

Dentist: _____
First name Last name

_____
Email address where CT report is to be sent to

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

Circle area of CBCT scan
& complete 'Reason for CBCT' in detail

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

Circle size preference 4x4 or 4x8 (vertically)

X-ray Date: _____
(Relevant X-rays PAN or PA required as per RCDSO)

Please check which radiologist (please check)

- **Canaray** $250.00 (visual and written report 100days)

Expedite options (please circle)

1-2 days $115 3-6 days $75
7-11 days $50 12-17 days $25

- With implant measurements additional cost $35
- **Orad** $200.00 (written report only in 20days)
- Send image via We Transfer

Reason for CBCT (Required be filled in detail including any anatomy required to be captured in imaging)

Kincardine Dentistry

6 Millennium Way Kincardine ON N2Z 0B5

In office use only

Date: _____

Radiologist: Canaray Expedite _____ Orad

Radiologist ID number: _____

We Transfer: _____ Uploaded by: _____

Version 3 - September 2023 - 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