

# Tall Pines Dental Centre

## CBCT REFERRAL FORM

10-201 Pioneer Drive, Kitchener, ON N2P 2A4

519-748-4532 | admin@tallpinesdental.com

www.tallpinesdental.com

### REFERRING CLINICIAN

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Additional results sent to: \_\_\_\_\_

### PATIENT INFORMATION

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of birth (mm/dd/yy): \_\_\_\_\_

### REGION OF INTEREST: (circle tooth area)

<b>Upper Right</b>								<b>Upper Left</b>									
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		
<b>Lower Right</b>								<b>Lower Left</b>									
<b>Upper Right</b>								<b>Upper Left</b>									
55	54	53	52	51									61	62	63	64	65
85	84	83	82	81									71	72	73	74	75
<b>Lower Right</b>								<b>Lower Left</b>									

### PRICING

SM 5x5 \$325

1 Arch 8x5 \$375 Upper  Lower

2 Arch 8x8 \$425

### REPORT URGENCY: (please check one)

ASAP +\$150  7-12 Days +\$50

1 Day +\$100  4mths+ No extra fee

3-6 Days +\$75

### RELEVANT CLINICAL DETAILS & HISTORY: (required)

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### INDICATIONS OF SCAN: (please check one)

Implant  Wisdom Teeth  Salivary Gland  Disease/Syndrome/Tumour/TMJ

Facial/Muscle Pain/Paralysis/Abnormal Sensation  Painful/Cracked/Troublesom Teeth (Endo)  Other

### REFERRAL DETAILS:

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