SAVANNA DENTAL GROUP

SCAN REFERRAL & REQUISITION

MANDATORY

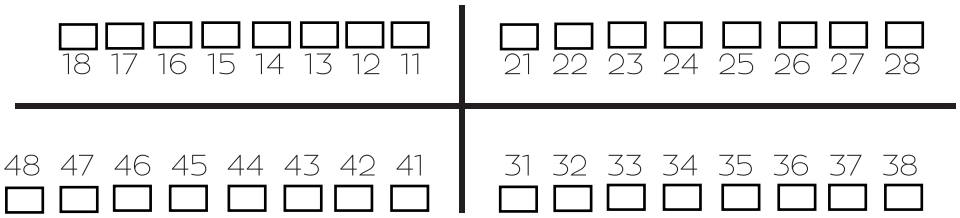
Referring Office/Dentist:_____

PATIENT (please print):_____ Sex (Circle) ☐ M ☐ F

Address: _____

Telephone:_____ Date of birth (DD/MM/YY):_____

PLEASE CIRCLE REGION(S) OF INTEREST



Indications for Scan:

1. Implants

☐ Implant planning ☐ Stent Provided ☐ Measurements

2. Surgery

☐ Wisdom teeth ☐ Impacted Teeth

3. Diagnostic

☐ Tmj Disease ☐ Dental Anomaly

4. Endodontics

☐ Root Fracture ☐ Dental Trauma ☐ Perforation ☐ Resorption
☐ Apical Pathosis ☐ Root Canal Anatomy

ADDITIONAL COMMENTS / CLINICAL INFORMATION/ SUSPECTED DIAGNOSIS:

Please indicate field of view required:

☐ Specific area (4x4) ☐ Complete maxillary arch (8x5) ☐ Complete mandibular arch (8x5)

Appointment Date:_____ Time:_____

IMPORTANT INFORMATION: Metallic jewelry needs to be removed for the scan.

PHONE: (519) 673-5293 **FAX:** (519) 673-6323 **ADDRESS:** 1135 ADELAIDE ST. NORTH. 3RD FLOOR SUITE #303. LONDON, ON. N5Y 5K7

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