##### A black text on a white background AI-generated content may be incorrect.



**DIAGNOSTIC IMAGING REFERRAL FORM**

**PATIENT INFORMATION:**

**(PLEASE PRINT)**

### Patient’s Name. Ph: / Cell: E-mail: DOB:

### Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMAGING SERVICE/FEE’S:**

**REGION OF INTEREST:** *(circle)*

|  |  |
| --- | --- |
| 8 7 6 5 4 3 2 1 **1** | **2** 1 2 3 4 5 6 7 8 |
| 8 7 6 5 4 3 2 1 **4** | **3** 1 2 3 4 5 6 7 8 |

# REFERRAL REASON + DETAILS:

## ADDITIONAL SERVICES:

 CBCT ENDO SCAN $195

 CBCT FOLLOW UP SCAN 5X5 $105 CBCT FOLLOW UP SCAN ARCH / MAXILLOFACIAL $135 CEPH ANALYSIS: $85

 CLINICAL PHOTOGRAPHY: (standard 8 photos) $85 ADDITIONAL PHOTO’S: # @ $5 / ea = $ $  NERVE TRACING &/or MEASUREMENTS (per quad) $65

 EXTRA COPY OF IMAGES or copy CD $20

# DOCTOR’S INFORMATION:

***CHARGE TO: *** ***Patient *** ***Doctor***



**OPTIONAL LOW DOSE** *(\*\* 17x13.5 not available)*

Referring Clinician: (ex. Dr. J. Smith)

**FOCUSED-FIELD MODES: (*regular dose, unless specified above*)**

\*ORAL MAXILLOFACIAL RADIOLOGICAL REPORT: $145

*(Suggested for 10x10 & 17x6)*

### Office Address: (office stamp)

Office Ph / Fax: E-mail: Referral Date:

***By signing, I hereby agree to release cdi – canadian digital imaging from any claims I may have, and to waive any and all claims I may have, now or in the future, and to hold harmless and indemnify, from any and all claims pursuant to any request for images or services provided for herein.***

### Doctor’s Signature:

##### (5x5) Implant/Impaction Scan (interpretation add I.C.) $195

**ARCH MODES: (*regular dose, unless specified above*)**

 SINGLE ARCH: (10x5) maxillary  mandibular *$255* DUAL ARCH: (8x8)  (10x10\* – incl. 3rd molar) *$305* DOUBLE SCAN PROTOCOL: (requires guide & bite reg.) *$70* **MAXILLOFACIAL: (*regular dose, unless specified above*)**

 \*\*FACIAL/AIRWAY/TMJ: (17 X 13.5 incl. radiology report) $505  TMJ/SINUS: (17x6\*) $295

 ORTHO/SINUS: (17 X 11 - includes radiology report) $505 DOULBE SCAN: 2nd or 3rd CBCT/ea – same appt. $70

Open, Closed Clenched, Relaxed, other:\_

PANORAMIC:



$100$80 FORWARD COMPLETED FORM TO:

LATERAL CEPH: (or indicate position)

## [info@cdikelowna.com](mailto:info@cdikelowna.com) or fax: 1-888-463-0167

***Call CDI at 250-862-2468 to arrange an appointment.***

**APPT. DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**APPT. TIME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**APPT. FEE: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### (WALK-IN WELCOME)

**OFFICE LOCATION: *#****221 – 1890 Cooper Rd,*

#### Orchard Plaza I (Across from Orchard Park Mall)

**OFFICE HOURS:** *9 – 4:30 (Monday-Thursday)*

|  |
| --- |
| <https://kelownaomtmj.ca>  Fax:1-888-463-0167  Tel: 236-301-5197  info@kelownaomtmj.ca |

##### DOUBLE SCAN 2nd or 3rd /ea – same appt. $35



AP, PA, Lateral, SMV, Oblique, Carpal Index: