ORAL & MAXILLOFACIAL RADIOLOGY

IMAGING AND INTERPRETATION REQUEST FORM

Radiology Clinic, 2nd Floor, 101 Elm Street Tel: 416.864.8344

PATIENT NAME: ______________________________, ______________________________
LAST NAME FIRST NAME

Sex: ☐ M ☐ F ☐ Other PHONE NUMBER: ____________________ DATE OF BIRTH: ____ / ____ / ________
DAY MONTH YEAR

ADDRESS: ____ CITY/PROVINCE: __________________

RADIOLOGIC IMAGES

ACQUIRE THE FOLLOWING IMAGES FOR ME

☐ CONE BEAM CT ☐ PANORAMIC
☐ LATERAL CEPH ☐ OTHER _________

Patient will be invoiced based on images acquired.

OR

I WILL PROVIDE THE IMAGES FOR INTERPRETATION

☐ SEND IMAGES (WITH ACQUISITON DATE) WITH REFERRAL FORM

Only 2D imaging is accepted at this time.
DDS will be invoiced $85 CAD for Report (subject to change).

REASON FOR REFERRAL

INDICATE THE REGIONS OF INTEREST:

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ PATHOLOGIC INVESTIGATIONS
- ☐ Intra-osseous
- ☐ Temporomandibular Joints
- ☐ Sialography

☐ IMPLANTS
☐ ENDODONTICS
☐ LOCALIZATION OF IMPACTED TEETH

PROVIDE RELEVANT CLINICAL INFORMATION:

DDS INFORMATION

REFERRING DDS: ______________________ SIGNATURE: ______________________

PRACTICE NAME: ______________________ PRACTICE PHONE: ______________________

PRACTICE ADDRESS: ____

PRACTICE EMAIL: ____

PLEASE UPLOAD THIS REFERRAL FORM AND RELEVANT RADIOLOGIC IMAGES
USING THE SECURE DENTDOX FILE TRANSFER SYSTEM AT:
https://dentdox.dentistry.utoronto.ca/filedrop/xrays

v 24.7