GREAT ◆ LAKES
ORAL & MAXILLOFACIAL
SURGERY CENTRE

Cone Beam Referral/Request:

Patient Name: _____ **D.O.B.:** _____ **Sex:** _____

Address: _____

Referring Dentist: _____
Copies of Report also sent to: _____

A. IMPLANT RELATED SERVICES

Date Required _____

Please specify site(s)

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

Study Results ☐ Stent Provided

☐ With Measurements ☐ CD with Images

B. ORTHODONTIC RELATED

☐ 3D ceph

☐ Position of Impacted/Unerupted Teeth

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

C. ENDODONTIC RELATED

☐ Identification of Specific Canal ☐ Root/Tooth Fracture

D. SPECIAL PROCEDURES

Reason for Referral _____

Provisional Diagnosis _____

☐ Maxillary ☐ Mandibular ☐ TMJ ☐ Proximity of roots to vital structures

STUDIO 700 ◆ 1825 MANNING ROAD ◆ RR#1 ◆ TECUMSEH ◆ ON ◆ N8N2L9
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