Interpretation Only Request Form

(DD/MM/YYYY)

Patient Name: ………………………………………………………………………….Birthday: ……………………………………….

Referral Doctor Name & Address: ……………………………………………………………………………………………

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Referral Doctor's Phone Number: ……………………………………………………………………………………………

☐ **CBCT** ☐ **Panoramic** ☐ **Periapical** ☐ **Bite-Wings**

NOTE: (for all uploads to dropbox)

1. Send us your preferred email for free account registration @implantctscan@yahoo.ca.
2. Name the upload folder with patients' first & last name along with images capture date. Please attach a copy of the interpretation form inside the folder.
3. All CBCT scans – please upload them as Multiply Dicom Format.

Type of reply:

☐ **Written Report** ☐ **Quote before proceed? (We are NO longer provide verbal reply)**

Question or concern about the imaging(s):

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Referring Doctor's Signature……………………………………………………………………………………………….

Note: All completed reports are non-refundable.

Elaine C. Orpe, B.Sc., D.M.D., Diploma in Oral Radiology, M.Sc. (Dentistry), F.R.C.D.(C)
Certified Specialist in Oral & Maxillofacial Radiology
Tel: 604-808-7226 Email: implantctscan@yahoo.ca website: www.dentalctscan.ca