# **C-T Scan / X-Ray Interpretation Only 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 Synrigi.Care)**

1. Please don't send CD/USB as we now use a secure online server system. 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 scans 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
211-3665 Kingsway Avenue, Vancouver BC V5R 5W2
Tel: 604-432-7226 Fax: 604-432-7222 Email: implantctscan@yahoo.ca website: www.dentalctscan.ca