

CBCT REFERRAL FORM

Dr. Farzin Mirzaeeyan
104 - 2904 Highway 7
Vaughan, Ontario
L4K 0K1



EXPO CITY DENTAL

PATIENT INFORMATION

PATIENT NAME

PATIENT ADDRESS

DOB (D/M/Y)

EMAIL

TELEPHONE

DATE SUBMITTED

REASON FOR REFERRAL

TOOTH NUMBER

AREA

2D IMAGES INCLUDED

REFERRAL GUIDELINES AND INSTRUCTIONS

FORM TO BE COMPLETED BY
REFERRING DENTIST

PATIENT REFERRAL FORM TO
BE SCANNED AND PLACED
INTO PATIENT CHART

PATIENT TO BE NOTIFIED OF
FINDINGS

REPORTING AND
INFORMATION REGARDING
PATIENT INFORMATION TO BE
RECORDED IN PATIENT CHART

ADDITIONAL INFORMATION

COMPLETED SCAN INFORMATION

DATE RECEIVED

DATE PATIENT CONTACTED

DATE OF SCHEDULED SCAN

REPORTING PROVIDED BY

DATE PATIENT NOTIFIED OF REPORTING INFORMATION (D/M/Y)

REPORTING INFORMATION ADDED TO PATIENT CHART

NOTES

Referring Dentist _____ Signature _____