

# NEWMARKET ORAL SURGERY NOS SPECIALTY GROUP

## CBCT Referral Form

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Email \_\_\_\_\_

Other Doctor(s) to receive copies of the report:

Name(s) \_\_\_\_\_ Email(s) \_\_\_\_\_

Reason for Referral (Include any special instructions)

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Pertinent Clinical Information

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**If applicable, please send any recent radiographs or imaging, along with their reports, for the area of clinical interest.**

Indicate Radiologist Group for reporting:

Canaray     OMRA     Huronia     Other \_\_\_\_\_

If not specified, then scan will be sent to Canaray.

Standard turnaround times vary by radiologist group.

If an expedited report is required, please specify your desired timeframe:

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