HURONIA
Maxillofacial
RADIOLOGY

Huronia Maxillofacial Radiology
C. Grace Petrikowski DDS, MSc, FRCD(c)
Oral and Maxillofacial Radiologist

Referral for Diagnostic Imaging

Patient: _____ D.O.B.: _____

Appt. date & time: _____ Telephone: _____

Parent's Name (if minor): _____ Approx. fee: _____

CONE BEAM COMPUTER TOMOGRAPHY

□ **TMJ** *(please check all that apply)*
□ close □ open □ bite registration □ _____

□ **Airway Analysis** *(3D Images)*

□ **Implants** *(please circle areas of interest)*

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

□ patient will bring stent

Image output:
□ Measurements
(vertical measurements made from a minimum of _____mm crestal width)
□ Hard copy prints
□ DICOM files
□ Viewing software
□ Simplant file
□ Email images to: _____

CONVENTIONAL IMAGING

□ Panoramic
□ Lateral cephalometric
□ Cephalometric analysis _____
□ Lateral cervical spine
□ Posterior-anterior cephalometric
□ Other _____

DIGITAL PHOTOGRAPHY

□ extraoral □ intraoral □ 3D facial photographic scan

Instructions and patient history _____

_____

_____

_____

Referred by Doctor _____ **Date** _____

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