TOMKEN CENTRE DENTISTRY

925 Rathburn Rd. Unit C1
Mississauga, Ont. L4W 4C3
Tel : (905)848-2250

CBCT Referral Slip

Introducing, Patient Name: (First Last) MR./MRS._____

DOB (D/M/Y):_____/_____/_____

Address: Contact # (____)_____-_____

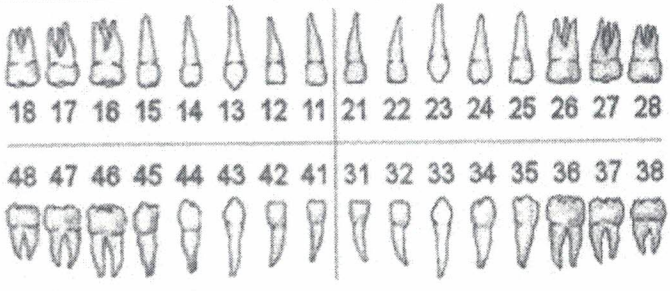
_____ Alt Contact # (____)_____-_____

_____ Email: _____

_____

Reason for Referral (Please circle):

Endodontic CBCT	Implant CBCT	Wisdom Teeth CBCT	Impacted/supernumerary CBCT
TMJ open + closed CBCT	Pathology CBCT	Orthognathic surgery CBCT	Other:



Special Instruction: _____

_____

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_____

Prescribing Dentist: _____

Signature: _____ Date: _____