



# Tomken

D E N T A L

## LIMITED FIELD OF VIEW CBCT REFERRAL

CBCT Imaging • Implant Planning • Digital Workflow

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### PATIENT INFORMATION

Patient Name

Phone

Date of Birth

Email



### REFERRAL DETAILS

TOOTH / AREA OF INTEREST

REASON FOR REFERRAL

- Implant Site Assessment
- Endodontic Evaluation
- Surgical Extraction Planning
- Impacted Tooth Assessment
- Periapical Pathology
- Root Resorption
- Orthodontic Evaluation
- Trauma Assessment
- Other \_\_\_\_\_



### ADDITIONAL SERVICES

- Prime Scan (Digital Impression)
- Implant Planning
- Surgical Guide Fabrication
- Implant Planning + Surgical Guide
- Contact Patient Directly to Schedule
- Other \_\_\_\_\_



### CLINICAL NOTES

  
  
  


### REFERRING DOCTOR

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

Office Name \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



A copy of the CBCT images and report will be forwarded to the referring office upon completion.



Thank you for your referral.  
We appreciate your trust.