CBCT REFERRAL FORM

Dr. Moemen Metwally
2804 Victoria Park Ave #14
North York, ON
M2J 4A8

Van Horne Dental

PATIENT INFORMATION	
PATIENT NAME	
PATIENT ADDRESS	
DOB (D/M/Y)	
EMAIL	
TELEPHONE	
DATE SUBMITTED	

REASON FOR REFERRAL	
TOOTH NUMBER	
AREA	
2D IMAGES RECEIVED	

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 _____