B225-3122 Mount Lehman Road
Abbotsford, BC V2T 0C5
P: 604-381-3399 / F: 604-381-3393
info@360dentalspecialists.com

360 Dental Specialists

3D IMAGING / CBCT
Referral Form

PATIENT INFORMATION

Full Name_____

Address: _____PC: _____

Phone: _____ Date Of Birth: _____

___ Male ___ Female

REFERRING DOCTOR INFORMATION

Full Name: _____

Address: _____

Phone: _____ Email: _____

PATIENT APPOINTMENT

Field of View: 40 x 40mm / 60 x 60mm / 80 x 80mm / 80 x 110mm

PLEASE CIRCLE THE REGION OF INTEREST (ROI)

Location: Maxilla | Mandible | Both Arches | TMJ

indicate teeth or	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
area of interest :	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Anticipated Procedure: _____