McGill | Faculty of Dental Medicine and Oral Health Sciences | Faculté de médecine dentaire et des sciences de la santé orale

752 Sherbrooke Street West, Montreal, QC H3A 1G1
514-398-3155
clinic.dentistry@mcgill.ca

Didem Dagdeviren
DDS, MSc, PhD, FRCD(C), Dip. ABOMR
Oral and Maxillofacial Radiologist

Requisition for Oral and Maxillofacial Imaging

Please email this form to **clinic.dentistry@mcgill.ca**. We will call your patient to set up an appointment.

PATIENT	**REFERRING DENTIST**
Name	Name
Date of Birth	Email
Gender _____M ____F	Phone number
Phone number	Address
Email address	

Clinical Information

Indicate the area of interest

Right side								Left side							
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

REASON FOR IMAGING

Please check all that apply

3D Imaging (CBCT)

- ☐ Evaluation of implant site
- ☐ Impacted tooth
- ☐ TMJ problem
- ☐ Periapical pathology
- ☐ Root fracture
- ☐ Pathology
- ☐ Consultation for a radiographic lesion
- ☐ Other: please specify _____

☐ One arch $310 ☐Two arches $385 ☐Large Field $485 (i.e. orthodontics, TMJ cases...)

2D Imaging: ☐ Panoramic - $109 ☐ Cephalometric - $109 ☐ Other (please specify)_____

Format for the report

Electronic package - This includes InVivo 6 software to view the study, the DICOM folder and a radiologic report

SEND BY

☐ email ☐ CD

_____ Date

_____ Signature – DMD/DDS