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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	E-mail
Gender _____M ____F	Phone number
Address	Address
Phone number	

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 (☐ With radiographic guide)
☐ Implant simulation (indicate implant type_____)
☐ Impacted tooth
☐ TMJ problem
☐ Periapical pathology
☐ Root fracture
☐ Pathology
☐ Consultation for a radiographic lesion
☐ Other Specify:_____

2D Imaging: ☐ Panoramic - $80 ☐ Other. Specify:_____

Format for the report
Electronic package - This includes a CD with InVivo 6 or i-Dixel software to view the study, the DICOM folder and a radiologic report via email.
☐ One arch $225 ☐ Two arches $275 ☐ Only report for a CBCT scan $100

_____ _____

Date Signature – DMD/DDS