THE DAVIS CLINIC
FOR ORAL & FACIAL SURGERY

10 Disera Drive, Suite 210, Thornhill, ON | (905) 881-2171 | davisclinic.ca

Oral Radiology Requisition Form

Patient Name: _____ Referral Date: _____

Tel: _____

Referring Doctor: _____

Images Required

➧ Conventional Imaging

☐ Panoramic

➧ CBCT

☐ TMJ R L

☐ Lesion

☐ Implant

☐ Endodontic Assessment

☐ Extraction Assessment and Nerve Localization

☐ Trauma

Area of Interest:

Q1	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8	Q2
Q4	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8	Q3

Comments:

_____

_____

_____

Delivery Specification

Send via e-mail to: _____

Implant Data Formatting

☐ Nobel Clinician ☐ DICOM

Send via mail (+ $15.00) to: _____

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