174 Guelph St.
Georgetown, ON L7G 4A7

Phone: (289) 891-6669
Fax: (289)-891 -6698

GEORGETOWN
Sleep Dentistry

Dental CBCT Referral Form

To make a referral, please complete the form below and email to info@georgetowndentists.ca

PATIENT DETAILS

Full Name (First, Last)

DOB

phone Number

Address

Contact Name (please fill if different from above)

REFERRER DETAILS

Referring Dentist Name

Clinic Name

Address

Number

Email

REFERRAL DETAILS

Reason for referral:

Anatomical area/ teeth to be scanned:

Radiographs

O Take as needed O Sent with patient O Attached O Emailed O Mailed

Date taken:

Additional comments

Reporting of the scan:

- I wish Georgetown Sleep Dentistry to provide me with a basic report on my patient's scan.
- I wish Georgetown Sleep Dentistry to provide me with a report and treatment plan on my patient's scan.

Future Treatment:

- Please send this patient back.
- Please accept this patient for treatment and send back for regular recalls.
- Please accept this patient for all future treatments.

Thank you for your referral, if you have any questions or concerns, please don't hesitate to contact us!

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