Please complete and email to: **webbookings@qscan.com.au**
OR upload securely to our website: **qscan.com.au/bookings**

Qscan RADIOLOGY CLINICS

Dental Referral

Patient name:

Address:

Phone: Mobile:

Birth date: WorkCover claim number:

EXAMINATION REQUESTED

BASIC IMAGING

☐ OPG ☐ TMJs ☐ Maxillary Sinuses

CEPHALOMETRY

☐ Lateral ☐ PA

MANDIBLE

☐ Lateral ☐ Townes ☐ Obliques ☐ PA

WATERS PROJECTION FOR IMPACTED CANINES

☐ Open mouth ☐ Closed mouth

CT CONE BEAM

☐ Upper Dentition ☐ Lower Dentition ☐ Entire Dentition ☐ Small FOV (5x5)

☐ CBCT TMJ's (open) ☐ CBCT TMJ's (closed) ☐ CBCT TMJ's (open & closed) ☐ Sure Smile Protocol

CT Dentascan

☐ Upper Dentition ☐ Lower Dentition ☐ Entire Dentition

MRI TMJ's

☐ MRI TMJ's

CLINICAL DETAILS

☐ Exclude ☐ Investigate ☐ Monitor ☐ Confirm

REFERRING PRACTITIONER

Name: Provider number:

Address:

Phone: Fax:

Signature: Date:

Send copy to:

Your doctor has recommended you attend Qscan Radiology Clinics. You may choose another provider but please discuss this with your doctor first.

BOOK AN APPOINTMENT

74402

Thank you for referring your patient to Qscan Radiology Clinics