DIAGNOSTIC IMAGING REFERRAL FORM

PATIENT INFORMATION:
(PLEASE PRINT)

Patient's Name. _____

Ph: / Cell:_____

E-mail:_____

DOB:_____

Address: _____

DOCTOR'S INFORMATION:

CHARGE TO: ☐ ***Patient*** ☐ ***Doctor***

Referring Clinician: (ex. Dr. J. Smith)

_____

Office Address: (office stamp)

Office Ph / Fax: _____

E-mail:_____

Referral Date:_____

By signing, I hereby agree to release cdi – canadian digital imaging from any claims I may have, and to waive any and all claims I may have, now or in the future, and to hold harmless and indemnify, from any and all claims pursuant to any request for images or services provided for herein.

Doctor's Signature:

_____

IMAGING SERVICE/FEE'S:

REGION OF INTEREST: *(circle)*

8 7 6 5 4 3 2 1 **1**	**2** 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 **4**	**3** 1 2 3 4 5 6 7 8

REFERRAL REASON + DETAILS:

_____

_____

_____

_____

☐ **OPTIONAL LOW DOSE** *(** 17x13.5 not available)*

FOCUSED-FIELD MODES: (***regular dose, unless specified above***)

☐ (5x5) Implant/Impaction Scan (interpretation add I.C.) $105

ARCH MODES: (***regular dose, unless specified above***)

☐ SINGLE ARCH: (10x5) ☐ maxillary ☐ mandibular *$245*

☐ DUAL ARCH: ☐ (8x8) ☐ (10x10* – incl. 3rd molar) *$295*

☐ DOUBLE SCAN PROTOCOL: (requires guide & bite reg.) *$70*

MAXILLOFACIAL: (***regular dose, unless specified above***)

☐ **FACIAL/AIRWAY/TMJ: (17 X 13.5 incl. radiology report) $495

☐ TMJ/SINUS: (17x6*) $285

☐ ORTHO/SINUS: (17 X 11 - includes radiology report) $495

☐ DOULBE SCAN: 2nd or 3rd CBCT/ea – same appt. $70

Open, Closed Clenched, Relaxed, other:_____

☐ PANORAMIC: $80

☐ LATERAL CEPH: (or indicate position) $60

☐ DOUBLE SCAN 2nd or 3rd /ea – same appt. $35

AP, PA, Lateral, SMV, Oblique, Carpal Index: _____

ADDITIONAL SERVICES:

☐	CBCT ENDO SCAN	$95
☐	CBCT FOLLOW UP SCAN 5X5	$95
☐	CBCT FOLLOW UP SCAN ARCH / MAXILLOFACIAL	$135
☐	CEPH ANALYSIS:	$85
☐	CLINICAL PHOTOGRAPHY: (standard 8 photos)	$85
☐	ADDITIONAL PHOTO'S: #_____@ $5 / ea = $	$____
☐	NERVE TRACING &/or MEASUREMENTS (per arch)	$55
☐	EXTRA COPY OF IMAGES or copy CD	$20
☐	OSA full digital records	$695
☐	ORTHODONTIC full digital records	$695
☐	*ORAL MAXILLOFACIAL RADIOLOGICAL REPORT: *(Suggested for 10x10 & 17x6)*	$135

FORWARD COMPLETED FORM TO:

info@cdikelowna.com or **fax: 1-888-463-0167**

Call CDI at 250-862-2468 to arrange an appointment.

APPT. DATE: _____

APPT. TIME: _____

APPT. FEE: $ _____

(WALK-IN WELCOME)

OFFICE LOCATION: *#221 – 1890 Cooper Rd, Orchard Plaza I (Across from Orchard Park Mall)*

OFFICE HOURS: *8 – 4:30 (M-Thurs) & 8-12 (Friday)*

www.cdikelowna.com

For updated schedule or online referral form.

Pricing as of June 2020