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: ____________________

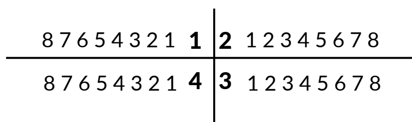
By signing, I hereby agree to release cdi – canadian digital imaging from any claims I may have, and to waive any and all claims I may have, now or in the future, and to hold harmless and indemnify, from any and all claims pursuant to any request for images or services provided for herein.

Doctor's Signature:

____

IMAGING SERVICE/FEE'S:

REGION OF INTEREST: (circle)



REFERRAL REASON + DETAILS

____

____

____

____

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

☐ 4X4 5X5 6X6 IMPLANT/IMPACTION/ENDO

$195

ARCH MODES: (regular dose, unless specified above)

☐ SINGLE ARCH ☐ 12x5 ☐ 8x5 ☐ 5x8 ☐ 10x5 $255

☐ DOUBLE ARCH ☐ 8x8 ☐ 10x10 ☐ 16x10 $305

☐ Double Scan Protocol: (requires guide &bite reg.) $105

MAXILLOFACIAL: (regular dose, unless specified above)

☐ Facial /Airway/TMJ (16x17 incl. radiology report) $505

☐ TMJ/SINUS (16X6) $295

☐ Right TMJ (Open and closed.) $295

☐ Left TMJ (Open and closed.) $295

☐ ORTHO/SINUS (16x12- Incl. radiology report) $505

☐ DOULBE SCAN: 2nd or 3rd CBCT/ea – same appt. $105

Open, Closed Clenched, Relaxed, other: ________

☐ PANAROMIC $80

☐ LATERAL CEPH: (or indicate position) $60

☐ LATERAL CEPH: (with Carestream Ortho Tracing) $140

☐ AP, PA, Lateral, SMV, Oblique, Carpal index (with report) $140

ADDITIONAL SERVICES

☐ CBCT ENDO SCAN $195

☐ FOLLOW UP SCAN 5X5 ☐ 4x4 ☐ 6x6 $105

☐ FOLLOW UP SCAN 10x5 ☐ 12x5 ☐ 8x5 ☐ 5x8 $135

☐ (16 x 12 &16 x 17) w/o radiology report ☐ 16x10 $275

☐ CLINICAL PHOTOGRAPHY (standard 8 photos) $85

☐ NERVE TRACING &/or MEASUREMENTS QUADRANT $65

☐ CEPH ANALYSIS & ANALYSIS $65

☐ OSA AND ORTHO full digital records Call CDI

☐ ORAL MAXILLOFACIAL RADIOLOGICAL REPORT $145

(Suggested for 16X12 & 16X17 (RUSH add $45)

☐ CSPINE JOINT (without radiology report) $305

☐ CSPINE JOINT (with radiology report) $450

FORWARD COMPLETED FORM TO:
info@cdikelowna.com or fax: 1-888-463-0167

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

APPOINTMENT DATE: ____________________

APPOINTMENT TIME: ____________________

APPOINTMENT 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 August 2022