Edmonton Diagnostic Imaging - EDI

6641-177th Street, Edmonton AB, T5T 4K3 (P) 780-483-1338 (F) 780-483-1393 info@edxi.com

Patient Referral Slip

Patient's Name: _____ DOB: _____
Last *First* *Day* *Month* *Year*

Telephone: _____ Male: ____ Female: ____
Home *Other*

Fee Estimate: _____ To be billed to: O Patient O Referring Dr. O IA ID#: _____

Today's Date: _____ EDI Appointment: _____
Day *Month* *Year* *Day* *Month* *Year* *Time*

Patient Information: (please read carefully)
48 hrs notice is required to avoid cancellation fee. Visa, M/C, Amex, Debit, Cash are accepted. *Cheques are not accepted* and **fees are payable at the time of appt.** By law, this referral slip with a Doctor's signature is required for your appointment to proceed. For further information on why you are being sent to EDI and for an explanation on the services requested please visit www.edxi.com.

CONE BEAM VOLUMETRIC SCAN

Relevant Notes: _____

_____

****Please provide additional clinical history on back****

O Pathological Investigation *(specify concern)*: _____

O Impaction/Supernumerary (*specify concern)*: _____

O Sinus Investigation O Airway

O Implant Maxilla: _____
specify site(s)

O Implant Mandible: _____
specify site(s)

O Digital Orthognathic Surgery O TMJ

O Medical Model Required O Digital Models

O **Digital Orthodontic Records** (taken from CBCT Scan)
Includes any or All of the following:
Digital Models with 3D Face wrap
Pathology Report
Panoramic
PA Cephalometric
Lateral Cephalometric
Ceph Analysis _____ *(specify type)*
Diagnostic Digital Photographs

****If there is an additional area of interest for the Scan that requires a full work-up ie. images, measurements etc. please check off all that apply in the section to the left****

INDIVIDUAL SERVICES

____ Panoramic ____ Lateral Cephalometric

____ Hand/Wrist ____ PA Cephalometric

____ Diagnostic Digital Photographs

____ X-Ray scanned for Digital Duplication

____ Intra-Oral Radiographs *(specify):* _____

Other_____

O **Standard Orthodontic Records** IR ____
O **Invisalign** PR____
FR____

____ Diagnostic Digital Photographs ____ Panoramic

____ Radiology Report ____ Hand/Wrist

____ Lateral Cephalometric ____ PA Cephalometric

____ Ceph Analysis *(specify type):* _____

Models: ____ *Unmounted* OR ____ *Mounted*

RADIOLOGY REPORTING SERVICES

O CBCT O TMJ MRI ****For Imaging taken Outside EDI**** O Plain Film(s)_____
specify type

Please specify area of concern: _____

Doctor's Signature: _____ **Office Stamp**

E-Mail: _____

See Location Map on Reverse - www.edxi.com