Book online: qscan.com.au/bookings
or email your referral: webrequests@qscan.com.au

Dental Referral

Patient name:

Address:

Phone: Mobile:

Birth date: WorkCover claim number:

EXAMINATION REQUESTED

DIGITAL X-RAYS

- ☐ OPG
- ☐ Lat Ceph
- ☐ PA Ceph
- ☐ Hand-Wrist Xray
- ☐ Other:____________________________

CONE BEAM CT

- ☐ Small FOV (Hi-res)
- ☐ Maxillary Dentition
- ☐ Mandibular Dentition
- ☐ Maxillary and Mandibular Dentition
- ☐ Maxilla incl. OMU
- ☐ Mandible incl. TMJ
- ☐ Orofacial (nasion to mandible)
- ☐ TMJ
- ☐ SureSmile Protocol

MULTISLICE CT

- ☐ Mandibular dentition (Dentascan)
- ☐ Maxillary dentition (Dentascan)
- ☐ Maxillary and Mandibular Dentition (Dentascan)
- ☐ Maxilla incl. OMU
- ☐ Mandible incl. TMJ
- ☐ Maxillofacial (nasion to mandible)
- ☐ TMJ

MRI

- ☐ TMJ
- ☐ Other:____________________________

CLINICAL DETAILS

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.

74402-0725