DENTAL RADIOLOGY CONSULTATION

Imagix B

RADIOLOGIE CHÂTEAUGUAY
230, boul. Brisebois, local 201
Châteauguay (Québec) J6K 0J6

RADIOLOGIE LAËNNEC
1100, ave Beaumont (angle l'Acadie)
bureau 104
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233, rue Turgeon, Bureau 104
Sainte-Thérèse (Québec) J7E 3J8

TÉL :
514 866-6622

TOLL-FREE:
1 866 916-6622

WEBSITE:
imagix.biron.com/en

REFERRING DENTIST

ADDRESS OR STAMP OF REFERRING DENTIST

Signature of referring dentist _____ # Licence _____ Date _____

REPORT
❑ French ❑ English

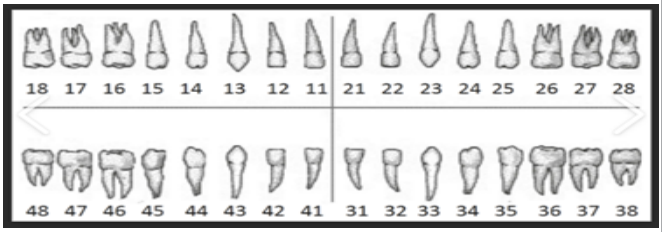
PATIENT

Name : _____ Date of birth : ____ / ____ / ____

Tel : _____ Email : _____

❑ CNESST ❑ SAAQ PREGNANT ❑ YES ❑ NO

MANDATORY CLINICAL INFORMATION



TECH. : DAP: NB OF IMAGES:

FOR A CBCT OR MRI EXAMINATION, PLEASE COMPLETE THE SECTION BELOW AND SEND US YOUR REQUEST THROUGH OUR WEBSITE. VISIT **IMAGIX.BIRON.COM/EN**. WE WILL CONTACT YOU TO SCHEDULE AN APPOINTMENT.

CONE BEAM COMPUTED TOMOGRAPHY (CBCT) ❶
with an appointment

❑ Maxilla
❑ Mandible
- ❑ Implant # tooth: _____
  - ❑ With radiological marker
  - ❑ Radiological marker only (dual scan)

❑ Localization of an impacted tooth and/or mandibular canal, # tooth: _____

❑ Search for pathology / lesion
Region : _____

❑ Temporomandibular joints
- ❑ 1 volume closed mouth position only
- ❑ 2 volumes open and closed mouth position

MAGNETIC RESONANCE ❷
with an appointment

❑ Temporomandibular joints
- ❑ Open and closed mouth
  - ❑ With bite

X-RAYS ❸
without an appointment

❑ Panoramic view
❑ Cephalometric view

❶ Examination offered at Imagix Laennec.
❷ Examination offered at Imagix Laennec, Imagix Ste-Thérèse et Imagix Chateauguay.
❸ Examination offered at Imagix Laennec et Imagix Ste-Thérèse.

MAGNETIC RESONANCE
IMPORTANT QUESTIONNAIRE FOR THE PHYSICIAN AND THE PATIENT TO COMPLETE

Last name : _____ First name : _____ D.O.B. : ____ /____ / _____

	YES	NO	
The patient has :	☐	☐	pacemaker
	☐	☐	metallic clip for aneurysm; specify : brain_____, neck_____, aorta
	☐	☐	metallic implant(s) or other (specify): _____
	☐	☐	hearing aid, artificial eye, dentures, hair prosthesis, artificial joint or other (specify): _____
	☐	☐	rods(s), plate(s), nail(s), screw(s), following a fracture or surgery (specify):_____
	☐	☐	body piercing(s)
	☐	☐	tattoo(s) and other: _____
	☐	☐	magnetic false eyelashes
The patient:	☐	☐	other (specify): _____
	☐	☐	has undergone surgery in the previous 12 weeks.
	☐	☐	is claustrophobic (if yes, plan for medication).
	☐	☐	is pregnant (number of weeks): _____
	☐	☐	has allergies (specify): _____
	☐	☐	has glaucoma.
	☐	☐	has previously been injured in the eye(s) by a metal object (specify): _____
	☐	☐	has previously undergone an MRI scan (specify): _____

Patient's weight: _____ Patient's height: _____

I have completed the above questionnaire with my physician. I confirm that the information is correct and consent to the MRI scan.

Date : _____ Dentist's signature: _____ Patient's signature: _____

WHERE TO FIND US

MONTÉRÉGIE
Radiologie Châteauguay
230, boulevard Brisebois, local 201
Châteauguay (Québec) J6K 0J6

MONTRÉAL
Radiologie Laënnec
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LAURENTIDES
Radiologie Sainte-Thérèse
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Book an appointment online : **imagix.biron.com** | FAX: **514 738-1883**