DENTAL X-RAY CONSULTATION

Imagix

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REFERRING DENTIST

REFERRING DENTIST
ADDRESS OR STAMP

Referring dentist signature _____ Licence # _____ Date _____

REPORT
❑ French ❑ English

PATIENT

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

Tel: _____ Email: _____

❑ CNESST ❑ SAAQ PREGNANT ❑ YES ❑ NO

MANDATORY CLINICAL INFORMATION

TECH.: DAP: NB IMAGES:

FOR A CBCT OR AN MRI, PLEASE COMPLETE THE SECTION BELOW AND SEND US YOUR REQUEST VIA EMAIL TO **RX@IMAGIXMEDICAL.COM**.
WE WILL CONTACT YOU TO SCHEDULE AN APPOINTMENT.

CONEBEAM CT

❑ Implant
- ❑ Maxilla tooth #: _____
- ❑ Mandible tooth #: _____
  - ❑ With radiological guide
  - ❑ With guide only (double scan)

❑ Location of an impacted tooth and/or mandibular canal
Tooth #: _____

❑ Pathology / lesion search
Region: _____

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

MRI

❑ Temporomandibular joints
- ❑ Mouth open and closed
  - ❑ With bite

X-RAY

❑ Panoramic view
❑ Cephalometric view

MAGNETIC RESONANCE IMAGING (MRI)
IMPORTANT QUESTIONNAIRE TO BE COMPLETED BY THE PHYSICIAN AND THE PATIENT

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

	YES	NO	
The patient has:	☐	☐	a cardiac pacemaker
	☐	☐	cerebral, neck or aorta metallic clip(s). Specify: _____
	☐	☐	metallic implant(s) or other devices. Specify: _____
	☐	☐	prosthesis(-es): auditory, ocular, dental, capillary, joint or other. Specify: _____
	☐	☐	rod(s), plate(s), nail(s), screw(s), as a result of a fracture or surgery. Specify: _____
	☐	☐	body piercing
	☐	☐	tatoo(s)
	☐	☐	other(s). Specify: _____
The patient:	☐	☐	has had surgery within the last 12 weeks
	☐	☐	is claustrophobic (if yes, plan medication)
	☐	☐	is pregnant. Number of weeks: _____
	☐	☐	has allergies. Specify: _____
	☐	☐	has glaucoma.
	☐	☐	has had a prior eye injury involving a metallic foreign body. Specify: _____
	☐	☐	has already had an MRI. Specify: _____

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

I have completed the above questionnaire with my physician. I confirm that the information provided is accurate and I agree to undergo the magnetic resonance imaging examination.

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

WHERE TO FIND US

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