WEST COAST RADIOGRAPHICS AND CONSULTING

Dr. Dorothy A. Sonya Inc.

Tel: 604-535-3028 Fax: 604.535.0769

Name: _____

DOB: ___ ___ / ___ ___ / ___ ___ ___ ___
M M D D Y Y Y Y

PHN: _____

Address: _____

_____

Phone: _____

Cell: _____

SURREY OFFICE ☐
Suite #310
1959 - 152nd Street
White Rock, BC V4A 9E3

BCCH ☐
Room K0162
4480 Oak Street
Vancouver, BC V6H 3V4

RADIOGRAPHIC EXAMINATION REQUESTED FOR:

1. _____

_____

2. _____

_____

SPECIAL INSTRUCTIONS:
(eg. Special positioning, restrictions, etc.)

Is patient MRSA positive? ☐ YES ☐ NO

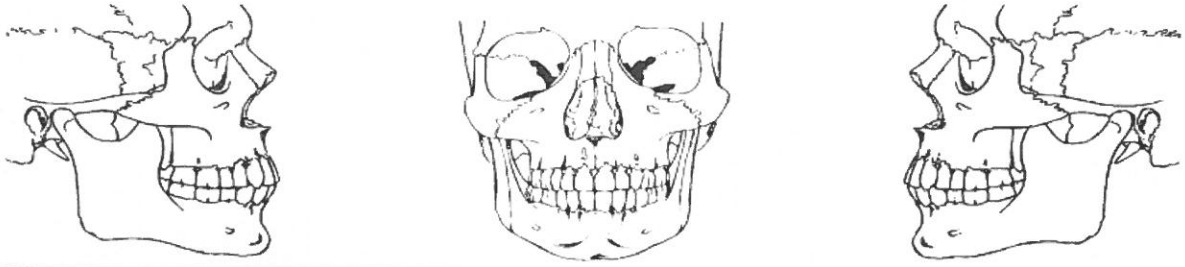
PERTINENT MEDICAL and DENTAL HISTORY:

MEDICATIONS:

PRIOR RADIGRAPHS: (Please provide copies if available)

☐ PA ☐ PAN ☐ PA CEPH ☐ CT
☐ BITE WING ☐ LATERAL CEPH ☐ CBCT ☐ MRI

PLEASE CIRCLE REGION OF INTEREST for IMAGING:



IF PATIENT REFERRED FOR IMPLANT ASSESSMENT:

A. SURGICAL STENT WILL BE PROVIDED? ☐ **YES** ☐ **NO**

B . IF DENTURE as STENT, PATIENT WILL WEAR:

☐ **MAXILLARY DENTURE**
☐ **MANDIBULAR DENTURE**
☐ **BOTH DENTURES**
☐ **NONE**

REFERRING DOCTOR (including address)

ADDITIONAL COPIES TO:

1.
2.
3.

VERBAL REPORT TO: (urgent requests only)

Doctor: _____

Phone #: _____

PATIENT SIGNATURE:

DATE

Please email requisition to dsonya@westcoastradiographics.com