




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
SURREY OFFICE <input type="checkbox"/> Suite #310 1959 - 152nd Street White Rock, BC V4A 9E3	BCCH <input type="checkbox"/> Room K0162 4480 Oak Street Vancouver, BC V6H 3V4	PHN: _____ Address: _____ _____ Phone: _____ Cell: _____
RADIOGRAPHIC EXAMINATION REQUESTED FOR: 1. _____ _____ 2. _____ _____		SPECIAL INSTRUCTIONS: (eg. Special positioning, restrictions, etc.) Is patient MRSA positive? <input type="checkbox"/> YES <input type="checkbox"/> NO
PERTINENT MEDICAL and DENTAL HISTORY: _____ MEDICATIONS: _____		
PRIOR RADIGRAPHS: (Please provide copies if available) <input type="checkbox"/> PA <input type="checkbox"/> PAN <input type="checkbox"/> PA CEPH <input type="checkbox"/> CT <input type="checkbox"/> BITE WING <input type="checkbox"/> LATERAL CEPH <input type="checkbox"/> CBCT <input type="checkbox"/> MRI		
PLEASE CIRCLE REGION OF INTEREST for IMAGING: <div style="display: flex; justify-content: space-around; align-items: center;">    </div>		
IF PATIENT REFERRED FOR IMPLANT ASSESSMENT: A. SURGICAL STENT WILL BE PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO B. IF DENTURE as STENT, PATIENT WILL WEAR: <input type="checkbox"/> MAXILLARY DENTURE <input type="checkbox"/> MANDIBULAR DENTURE <input type="checkbox"/> BOTH DENTURES <input type="checkbox"/> 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