Nordel Crossing Imaging

www.nordelsmiles.ca

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infoweb@nordelsmiles.ca • 604-593-7866

DATE: ______________________

PATIENTS NAME: ______________________

PATIENT PHONE: ______________________

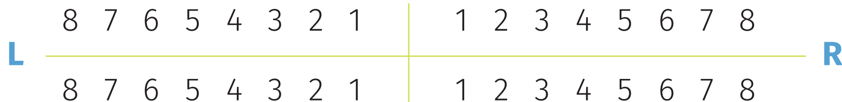
REFERRING DOCTOR INFO

NAME: ______________________ **OFFICE PHONE:** ______________________

EMAIL: ______________________

OFFICE NAME: ______________________

TREATMENT



CBCT FOV Size: Ø110 x 80 mm

ADDITIONAL COMMENTS:

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WE WILL PROVIDE A LINK TO DOWNLOAD CBCT SCAN VIA EMAIL.
PATIENT MUST CALL US TO BOOK. PLEASE EMAIL OR FAX REFERRAL SLIP IN ADVANCE.

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