



# ORAL MAXILLOFACIAL IMAGING CENTRE CALGARY

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Services provided by Specialists in Oral Maxillofacial Radiology

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
Please Print DD/MM/YY

Male  Female For female patients: Is pregnancy a possibility?  Yes  No

**Address:** \_\_\_\_\_ **Tel:** \_\_\_\_\_

**Referring Dr's Name:** \_\_\_\_\_ **Dr's Signature:** \_\_\_\_\_ **Tel:** \_\_\_\_\_

**Referral Date:** \_\_\_\_\_  Charge Doctor  Charge Patient

\*24 Hour notice of cancellation requested. Payment is required at the time of service. (Debit, Visa, M/C, American Express, Cash)

## New Tom VGi Volumetric Scan

- TMJ Survey: \_\_\_\_\_
  - TMJ Survey with additional positions (please specify): \_\_\_\_\_
  - Implant Study Maxilla with measurements (sites): \_\_\_\_\_
  - Implant Study Mandible with measurements (sites): \_\_\_\_\_
  - Upper Airway Investigation / Sinuses: \_\_\_\_\_
  - Lesion Investigation in the Maxillofacial Complex: \_\_\_\_\_
  - Localization Study / impacted, Supernumerary Teeth: \_\_\_\_\_
- Separate Arches:  Yes  No
- STENT:  To be sent to our office  Patient to bring to appointment
  - DICOM Only (no measurements) with report on incidental findings (please specify): \_\_\_\_\_

**Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Orthodontic Records

- Initial  Progress  Final
- Panoramic  Lateral Cephalometric  P-A Cephalometric  Hand / Wrist
- Cephalometric Analysis (please specify): \_\_\_\_\_

## General Dental Records

- Panoramic  Full Mouth Survey  Periapicals (please specify): \_\_\_\_\_
- Occlusal (please specify)  Mandibular Standard  Mandibular Anterior
- Maxillary Vertex  Maxillary Standard  Maxillary Lateral
- Radiologic Interpretation on films from other sources: \_\_\_\_\_
- External CBCT (Reformatting / Interpretation): \_\_\_\_\_
- MRI Interpretation: \_\_\_\_\_
- Duplication of radiographs: \_\_\_\_\_

**Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For appointments please call: (403) 547-OMIC (403) 547-6642 Fax: (403) 547-6607**