

DENTAL IMAGING REQUEST

REFERRAL REQUEST

Dr Tinku Kooner • Dr Mansoor Parker • Dr Pon Ketheswaran • Dr Kenneth Cooke • Dr David Chadban
Dr Bit Wong • Dr Prasad Kundum • Dr Sandeep Tiwari • Dr Georges Hazan • Dr Cathy Nicholas
Dr Tom Sing • Dr Frankie Wong • Dr Farhana Younis • Dr Kuan-Ching Ho • Dr Heba Abdelrahman
Dr Saima Khokhar • Dr Katherine Wong • Dr Ahmed Bassiouny • Dr Dhivya Balasubramaniam
Dr Jonathan Tow • Dr Ragu Yogaratnam • Dr Hans Van Der Wall



MONDAY TO FRIDAY 8:00am - 5:00pm

Name: _____ D.O.B: ____/____/____

Address: _____

Phone: _____

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8	7	6	5	4	3	2	1	1	2	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	4	3	1	2	3	4	5	6	7	8

L

MAXILLA

Region of Interest (please indicate)

MANDIBLE

SERVICE REQUESTED

STANDARD DENTAL X-RAYS

☐ OPG

☐ LAT CEPH

☐ TMJ'S

☐ PA CEPH

☐ MANDIBLE

☐ CT SINUSES (Medicare restrictions apply)

☐ CT MANDIBLE (Medicare restrictions apply)

CLINICAL NOTES / INSTRUCTIONS

☐ IMPACTED TEETH

☐ 3RD MOLARS

☐ ORTHODONTIC PLANNING

☐ MANDIBLE

☐ OTHER _____

☐ EXAMINE DENTITION

☐ IMPLANT PLACEMENT

☐ MAXILLOFACIAL SURGERY

☐ TRAUMA

☐ Urgent

☐ More Request Pads

☐ Films

☐ Disc

Bulk Billing

For Medicare Eligible Items

REFERRER DETAILS

Name:

Address:

Phone:

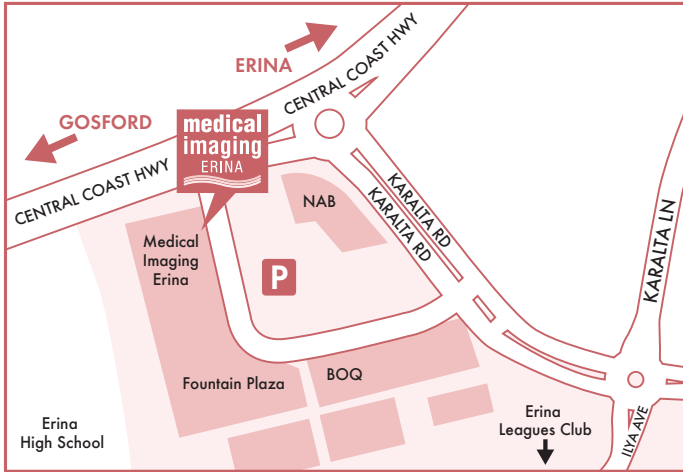
Signature:

Specialty:

Provider No:

Date:

EXPERIENCE INNOVATION



ERINA

18A Fountain Plaza
148-158 Central Coast Hwy
Erina NSW 2250
T: 02 4363 9300 F: 02 4367 7288
Monday - Friday 8:00am - 5:00pm

OPG	LAT CEPH	ULTRA LOW DOSE CT
•	•	•

Your doctor has recommended that you use Quantum Radiology. You may choose another provider but please discuss this with your doctor first.

Preparation: _____

Appointment Time..... DATE/...../.....

Please bring all previous X-Rays to examination

BANKSTOWN BLAXLAND CHESTER HILL ERINA LEICHHARDT MT DRUITT PENRITH SPRINGWOOD ST MARYS
T: 02 8760 9100 T: 02 4702 3655 T: 02 8713 1855 T: 02 4363 9300 T: 02 9569 7223 T: 02 9854 0100 T: 02 4722 4700 T: 02 4702 3661 T: 02 9623 2550