midtown.
EDMONTON PERIODONTICS

CBCT IMAGING – DIAGNOSTIC REPORT
Doctor to Doctor

CLINIC INFORMATION

Referring Office / Provider: Date:

Referring Dentist / Specialist:

Receiving Provider (Reporting Doctor): Midtown Edmonton Periodontics

Reporting Doctor:

Phone: Fax: Secure Email:

PATIENT INFORMATION

Introducing (Name): DOB:

Chart / File Number:

EXAMINATION INFORMATION

Date of CBTC Scan:

Indication for CBCT Scan (check all that apply):

- ☐ Implant Planning
- ☐ Periodontal Assessment
- ☐ Impacted Tooth / eruption disturbance
- ☐ Endodontic Evaluation
- ☐ Pathology / lesion investigation
- ☐ Surgical Planning
- ☐ Trauma
- ☐ Other:

AREAS OF INTEREST

☐ Maxilla ☐ Mandible ☐ TMJ ☐ Localized region (specify):

TECHNICAL INFORMATION

Field of View (FOV): Voxel Size (if applicable):

Image Quality: ☐ Diagnostic ☐ Limited - describe:

RADIOGRAPHIC FINDINGS

Teeth / Alveolar Bone:

Periodontal Structures:

Maxillary Sinuses / Nasal Cavity (if applicable):

Mandibular Canal / Mental Foramen (if applicable):

Temporomandibular Joints (if applicable):

PATHOLOGY / ANATOMICAL VARIATIONS

☐ No radiographic pathology identified

☐ Findings Noted:

IMPLANT-RELATED ASSESSMENT (IF APPLICABLE)

Bone Height:

Bone Width:

Proximity to anatomical structures:

Bone Quality (subjective):

SUMMARY, IMPRESSION, RECOMMENDATIONS

Summary / Impression:

Recommendations / Clinical Considerations:

This CBCT interpretation is limited to the region(s) reviewed and is based solely on the imaging data provided. Clinical correlation is required. This report does not replace a comprehensive clinical examination.

Name:

Signature:

Date: