



Note: CBCT scans eligible for a Medicare rebate require a referral from a Specialist Dentist or Medical GP.
Please be aware that Medicare or Health Fund may only cover part of the cost.

Patient Information

First Name: Surname: DOB: / /

Address: Suburb: Gender: F ☐ M ☐

State: Postcode: Contact #: Are you pregnant? Y ☐ N ☐

E-mail:

Next appointment with practitioner: / / (or date by which films are required)

Office use only

ID:

Entered by:

on: / /

Office use only

Developed by:

on / /

Verified and Posted by:

on / /

Health Fund:

You acknowledge your consent for this procedure by supplying your Health Fund card details.

Verbal consent given by the patient,

Referring Doctor to Complete

Doctors Name
Practice
Address
Suburb / PC

Speciality
Provider No.
Telephone No.
Email

Note that Medicare legislation only permits imaging and reporting of areas directly indicated

Clinical Indication: Please Specify

☐ Implants ☐ Impactions ☐ Endo ☐ Perio ☐ Orthodontic

☐ Cephalometric Tracing 081 (at additional cost to patient)
Please specify type:

Guide Included ☐ Yes ☐ No ☐ Teeth slightly separated (Biting on cotton rolls or gauze)

☐ CBCT Scan Acquisition 026
(Non Specialist Referrer Only)

Views Required: (Item codes relate to Health Fund Holders only)

☐ Maxillary Cross Section - Extraoral radiograph - 031 ☐ Mandibular Cross Section - Extraoral radiograph - 031

☐ Panoramic Radiograph 037 ☐ Airways - Base of Tongue ☐ Sinus ☐ Palatopharyngeal Study (Adenoids)

☐ TMJ 035 ☐ Clenched 035 ☐ Open 035 ☐ Protusion 035 ☐ At Rest 035

☐ Lat. Ceph 036 ☐ AP Ceph 036 ☐ PA Ceph 036 ☐ Occlusal View - SMV radiograph of the skull 033

☐ Other:

Area of Interest

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

Report Format Hard Copy ☐

CBLINK Website ONLY ☐

Do you require DICOM N ☐ Y ☐
Nobel Guide N ☐ Y ☐
Implant N ☐ Y ☐

Scan Authorisation

Dr Signature

Date: / /

I confirm that the patient has been assessed as suitable to undergo the prescribed scan.
This form confirms that patient agrees to Canada Bay Medical Imaging Pty Ltd providing diagnostic images.

This referral is valid for 3 months: Your doctor has recommended that you use Canada Bay Medical Imaging Pty Ltd.
You may choose another provider but please discuss this with your doctor first.

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Patient Information

First Name: Surname: DOB / /

Address Suburb Gender F ☐ M ☐

State Postcode Contact # Are you pregnant? Y ☐ N ☐

E-Mail

Next appointment with practitioner / / (or date by which films are required)

Medicare #

Position Card Expiry /

Office use only ID:

Entered by: on: / /

Office use only Developed by: on / /

Verified and Posted by: on / /

You acknowledge your consent for this procedure by supplying your Medicare or Health Fund card details.

Verbal consent given by the patient,

Referring Doctor to Complete

Doctors Name	<input type="text"/>	Speciality	<input type="text"/>
Practice	<input type="text"/>	Provider No.	<input type="text"/>
Address	<input type="text"/>	Telephone No.	<input type="text"/>
City/Suburb	<input type="text"/>	Fax No.	<input type="text"/>
Postcode	<input type="text"/>	Email	<input type="text"/>

Note that Medicare legislation only permits imaging and reporting of areas directly indicated

Clinical Indication: Please Specify

☐ Implants ☐ Impactions ☐ Endo ☐ Perio ☐ Orthodontic

Guide Included ☐ Yes ☐ No ☐ Teeth slightly separated (Biting on cotton rolls or gauze)

☐ Cephalometric Tracing 081 (at additional cost to patient)
Please specify type:

☐ CBCT Computed Tomography 57362 (Medicare Only)
(Specialist Referrer Only)

☐ 2D OPG only 57963 available at Sydney City only ☐ 2D Lat Ceph only 57902 available at Sydney City only ☐ 2D AP Ceph 57902 available at Sydney City only ☐ 2D PA Ceph 57902 available at Sydney City only

Views Required: Please select on the back of this referral

Area of Interest

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Report Format Hard Copy ☐ Vision ☐ CBLINK Website ONLY ☐

Do you require DICOM N ☐ Y ☐

Nobel Guide N ☐ Y ☐

Implant N ☐ Y ☐

Scan Authorisation

Dr Signature

Date

 / /

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Current Sites Available

Practice Location	Address	Opening Hours	Bookings Contact
Canada Bay	Canada Bay - Head Office 69 Great North Rd. Five Dock NSW 2046 (Entry: 69 Thompson Ln - Behind)	8:30AM – 5:30PM (Mon-Fri) (After hours by appointment only)	02 9713 0070
Sydney – CBD	Canada Bay Sydney City Suite 601, Level 6, 60 Park Street Sydney CBD NSW 2000	8:30AM – 5:30PM (Mon-Fri) (After hours by appointment only)	02 9713 0070

Enquire about our services by emailing reception@canadabaycentre.com.au or call
Dr Celso Nishiguchi or Vivien Munoz-Ferrada on 02 9713 0070