

# CT Scan Referral



Today's Date :

Patient's Name :

Phone :

Images required by (date) :

Referring Doctor :

Please check desired procedures :

- DICOM File    MX only    MD only    MX w/ OMC  
 Middle    Open Bite    Centric Occlusion

Please circle the area of concern

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

**Email address required to receive CT scan**

Office Stamp (Address & Phone)    BITES Institute Member

\* CT will be sent by email.

Please download within 4 weeks of arrival.

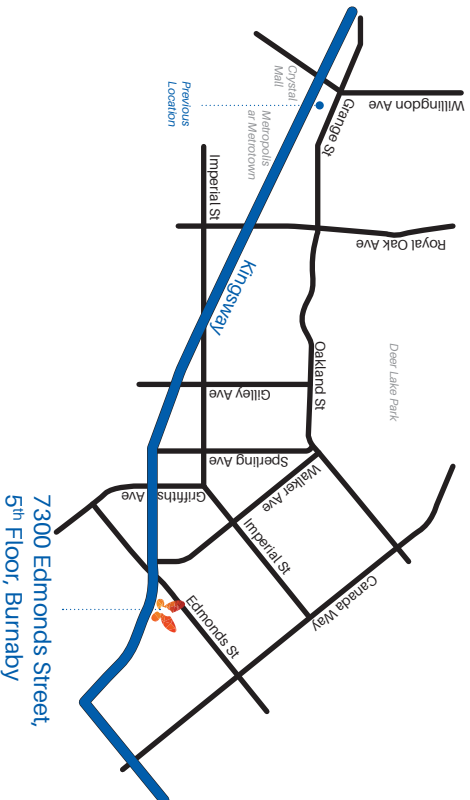
[www.implantmagic.com](http://www.implantmagic.com)

**7300 Edmonds Street, 5<sup>th</sup> Floor,  
Burnaby, BC, Canada V3N 0G8**

tel. 604 439 8885 | fax. 604 439 7881

email. [info@implantmagic.com](mailto:info@implantmagic.com)





7300 Edmonds Street,  
5<sup>th</sup> Floor, Burnaby

#### By Transit :

From Edmonds Station, take # 106 Bus via New West Stn, get off at Edmonds street @ Linden St. Walk 2 mins to 7300 Edmonds Street.

or #119 Bus via Metrotown Stn, get off at Kingsway @ Walker Ave, Walk 2 mins towards Edmonds Street to 7300 Edmonds Street. We are located on the 5th floor.

#### Parking information :

There is a free parking entrance at Edmonds street @ Linden Ave (blue "P" sign)  
Please park at Level 1, 2 or 3, take the elevator to the 5th floor.

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