



Imaging Request (CBCT- ICAT)

Dr. Vohn S. Rosang DMD, MCID, FRCDC

CERTIFIED SPECIALIST IN ORTHODONTICS

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Patient name: _____

Patient Telephone: _____ DOB: _____

Referred by: _____

Referring dentist to be billed

Reason for Study/History:

Area of Interest/Comments:

- Standard Cephalometric View
- Standard Panoramic View
- Maxilla 0.4 0.3 0.25 0.20 mm³ voxel size
(list area for imaging slices if desired) _____
- Mandible 0.4 0.3 0.25 0.20 mm³ voxel size
(list area for imaging slices if desired) _____
- Both maxilla & mandible 0.4 0.3 0.25 mm³ voxel size
(list area for imaging slices if desired) _____
- TMJ Complete 0.4 0.3 0.25 mm³ voxel size
- Extended Field of View (17 x 23 cm) 0.4 0.3 mm³ voxel size

Note: Smaller voxel scans have better resolution but expose the patient to more ionizing radiation. Please note that it is the responsibility of the referring doctor for diagnosis and management of any information produced by these images.

Reports: Printed i-CAT Vision CD DICOM CD PDF - email:



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