

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Welcome to Our Survey

**The Royal College of Dental Surgeons of Ontario (RCDSO) is reviewing its *Dental CT Scanners* Standard of Practice. Your feedback is important to us and will help inform updates to the Standard of Practice.**

**The survey should take approximately 10-20 minutes to complete.**

**Survey responses are saved when you click the 'Next' button and submitted when you click the 'Done' button. You may complete part of the survey and return later to edit your responses or finish the survey if you are using the same device and web browser that you used to start the survey.**

**The deadline to provide feedback is August 1, 2025.**

**All responses will be reviewed and a summary of the feedback will be provided to RCDSO's Council after the consultation closes. Your feedback is anonymous. Responses submitted from individuals on behalf of organizations will be attributed to the organization and not the individual.**

**If you would like to download a PDF list of the survey questions, [click here](#).**

**If you have any questions about this survey or RCDSO's Standards review and development process, please see RCDSO's [website](#) or email the Policy Team at [ctscannersconsult@rcdso.org](mailto:ctscannersconsult@rcdso.org).**

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Participant Type

**To ensure that we ask you relevant questions, we have developed different question sets for different respondents. Please choose the option that best reflects the perspective you will bring to this survey.**

\* 1. Are you a:

- ☐ General dentist (including retired)
- ☐ Specialist dentist (including retired)
- ☐ Dental student
- ☐ Patient/Member of the public
- ☐ Oral health care professional, other than dentist (e.g., dental hygienist, denturist, dental technician, including retired)
- ☐ Non-oral health care professional (e.g., nurse, doctor, pharmacist, etc., including retired)
- ☐ Person responding on behalf of an organization
- ☐ I prefer not to answer

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Specialist Type

\* 2. What is your primary specialty or, if you have retired, what was your primary specialty?

- ☐ Dental Anesthesiology
- ☐ Dental Public Health
- ☐ Endodontology
- ☐ Oral and Maxillofacial Radiology
- ☐ Oral and Maxillofacial Surgery
- ☐ Oral Medicine and/or Oral Pathology
- ☐ Orthodontics and Dentofacial Orthopedics
- ☐ Pediatrics
- ☐ Periodontics
- ☐ Prosthodontics
- ☐ Other (please specify)

- ☐ I prefer not to answer

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Dentist Characteristics

**If you have retired, please respond to the questions on this page based on your experience when you were practicing.**

\* 3. Where did you complete your highest level of dental education?

- ☐ Canada
- ☐ Australia, Ireland, New Zealand, or United States of America (countries that have a mutually recognized system of accreditation of training with the RCDSO)
- ☐ Other (please specify)

☐ I prefer not to answer

\* 4. How many years have you been in practice?

- ☐ 0-10 years
- ☐ 11-25 years
- ☐ 26+ years
- ☐ I prefer not to answer

\* 5. What is your primary practice environment?

- ☐ Solo private dental clinic (one or more locations with one dentist)
- ☐ Group private dental clinic (one or more locations with more than one dentist)
- ☐ Corporate dental clinic (practice with some degree of third-party ownership and/or business support)
- ☐ Not-for-profit dental clinic (e.g., public health, community health centre, hospital, school, community-based)
- ☐ Other (please specify)

☐ I prefer not to answer

\* 6. We would like to know more about your role(s) in your practice. Which of the following best describes your primary role(s) in dentistry? Please select all that apply.

- ☐ Owner/Principal
- ☐ Associate/Independent Contractor
- ☐ Employee
- ☐ Clinic/Practice Manager (either formally or informally)
- ☐ Other (please specify)

☐ I prefer not to answer

\* 7. Describe the general location(s) where you work or practice. Please select all that apply.

- ☐ Extra-large urban area (population of 500,000 or more)
- ☐ Large urban area (population between 100,000 and 499,999)
- ☐ Medium urban area (population between 30,000 and 99,999)
- ☐ Small urban area (population between 1,000 and 29,999)
- ☐ Rural and/or remote (population less than 1,000)
- ☐ Other (please specify)

- ☐ I prefer not to answer

\* 8. Do you currently provide clinical care?

- ☐ Yes
- ☐ No
- ☐ I prefer not to answer

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Organization Type

\* 9. Which organization are you responding on behalf of?

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Questions about the Patient Experience

**The College is interested in learning about patients' experiences with having computed tomography (CT) and/or cone-beam computed tomography (CBCT) scanning when visiting the dentist.**

**CT and CBCT scanners are imaging tools used to provide detailed 3D images of a patient's teeth, bone structure, and surrounding tissues. They are more detailed than standard 2D dental x-rays your dentist may take.**

**CT and CBCT scanning can be used by dentists for assessment, diagnosis, treatment planning, and other purposes—for example, to assist in dental implant treatment, diagnosing disorders of the jaw or bite, or detecting cysts or tumours.**

\* 10. Have you ever had a CT or CBCT scan related to treatment received from a dentist?

- ☐ Yes, once
- ☐ Yes, more than once
- ☐ No
- ☐ Not sure

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Patient Experience - CT/CBCT Scan

\* 11. Where was your scan performed?

- ☐ My general dentist's office
- ☐ A dental specialist's office (e.g., radiologist, oral surgeon, orthodontist, endodontist)
- ☐ A hospital or medical imaging centre
- ☐ Not sure

\* 12. What was the specific purpose of ordering the CT/CBCT imaging?

- ☐ To assist with dental implant treatment
- ☐ To assess impacted teeth or wisdom teeth
- ☐ To assist with endodontic treatment (e.g., root canal)
- ☐ To help diagnose temporomandibular joint (TMJ) disorder
- ☐ To help with orthodontic treatment planning
- ☐ To evaluate sinuses
- ☐ To assess trauma/fracture
- ☐ To detect cysts or tumors
- ☐ To conduct an airway analysis
- ☐ Other (please specify)

- ☐ Not sure



\* 13. Which of the following did your dentist or dental specialist do, and how effectively did they do it?

	Extremely effectively	Very effectively	Moderately effectively	Slightly effectively	Not at all effectively	Did not do this	Do not recall or N/A
Explained the reason for the scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Explained potential risks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Explained expected benefits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Involved me in decision-making	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Addressed my questions or concerns before the scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Helped me feel comfortable when receiving the scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Explained the results of the scan afterwards	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\* 14. How would you describe your overall experience in getting the scan?

- ☐ Very positive
- ☐ Somewhat positive
- ☐ Neutral (neither positive nor negative)
- ☐ Somewhat negative
- ☐ Very negative

15. **Optional:** Please feel free to elaborate on your answer above. For example, if you had a positive experience, what made it positive? If you had a negative experience, how could your experience have been improved?

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Patient Experience - CT/CBCT Scans

\* 16. Where were your scans performed? Check all that apply.

- ☐ My general dentist's office
- ☐ A dental specialist's office (e.g., radiologist, oral surgeon, orthodontist, endodontist)
- ☐ A hospital or medical imaging centre
- ☐ Not sure

\* 17. What was the main purpose of ordering the CT/CBCT imaging? Check all that apply.

- ☐ To assist with dental implant treatment
- ☐ To assess impacted teeth or wisdom teeth
- ☐ To assist with endodontic treatment (e.g., root canal)
- ☐ To help diagnose temporomandibular joint (TMJ) disorder
- ☐ To help with orthodontic treatment planning
- ☐ To evaluate sinuses
- ☐ To assess trauma/fracture
- ☐ To detect cysts or tumors
- ☐ To conduct an airway analysis
- ☐ Other (please specify)

- ☐ Not sure

\* 18. What was the reason you received more than one CT/CBCT scan?

- ☐ It related to a different treatment or issue
- ☐ There were issues with the scan and it needed to be redone
- ☐ For different stages of a treatment (e.g., planning, follow-up after treatment)
- ☐ To monitor changes over time (e.g., cysts, bone loss)
- ☐ Other (please specify)

- ☐ Not sure

\* 19. Which of the following did your dentist or dental specialist do, and how effectively did they do it? Please answer based on the most recent experience.

	Extremely effectively	Very effectively	Moderately effectively	Slightly effectively	Not at all effectively	Did not do this	Do not recall or N/A
Explained the reason for the scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Explained potential risks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Explained expected benefits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Involved me in decision-making	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Addressed my questions or concerns before the scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Helped me feel comfortable when receiving the scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Explained the results of the scan afterwards	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\* 20. How would you describe your overall experience in getting the scan? Please answer based on the most recent experience.

- ☐ Very positive
- ☐ Somewhat positive
- ☐ Neutral (neither positive nor negative)
- ☐ Somewhat negative
- ☐ Very negative

21. **Optional:** Please feel free to elaborate on your answers above. For example, if you had a positive experience, what made it positive? If you had a negative experience, how could your experience have been improved?

22. **Optional:** If you have had different experiences when receiving different CT/CBCT scans, please feel free to elaborate on what those differences were.

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### Patient Expectations for Dentists

\* 23. As a patient, how often do you expect your dentist to do the following when receiving a CT/CBCT scan?

	I expect this all the time	I expect this sometimes	I don't expect this	Not sure
Clearly explain the reason for the scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Explain the potential risks of the scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Explain the expected benefits of the scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Discuss alternative imaging or diagnostic options	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Try other types of imaging first (e.g., x-rays)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide the opportunity to ask questions and express concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Review the scan results with me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

24. **Optional:** Please feel free to elaborate on your answers above, or specify if there are any other steps that you expect a dentist to take when receiving a CT/CBCT scan.

25. **Optional:** Would you like to share any other thoughts about the use of CT or CBCT scans in dentistry to support the development of effective guidance for dentists?

Preliminary Consultation: *Dental CT Scanners* Standard of Practice

Questions for Dentists - CT and CBCT Use in Clinical Practice

**The College is interested in understanding how dentists are currently using computed tomography (CT) and cone-beam computed tomography (CBCT) scanning in their practice.**

\* 26. Do you use medical CT or any CBCT scanning in your dental practice (e.g., for treatment planning)?

- ☐ CT only
- ☐ CBCT only
- ☐ Both
- ☐ None

\* 27. How do you access CT/CBCT scanning in your practice?

- ☐ On site
- ☐ Outsourced
- ☐ Both
- ☐ Not applicable

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Questions for Dentists - Barriers to Use of CT/CBCT scanners

\* 28. What are the main reasons or barriers you face in having a CT/CBCT scanner on-site?  
Check all that apply.

- ☐ Limited clinical use
- ☐ Radiation risks associated with CT/CBCT
- ☐ Cost of scanner
- ☐ Education/training requirements
- ☐ RCDSO requirements
- ☐ Government regulatory requirements
- ☐ Other (please specify)

☐ Prefer not to answer

29. **Optional:** Please feel free to elaborate on your answer above. For example, are there specific requirements that pose barriers? What supports would help you use CT/CBCT more effectively in your practice?

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Questions for Dentists - Use of CT/CBCT scanners

\* 30. What type of CT/CBCT scanner do you use? Check all that apply.

☐ CBCT scanner - dentoalveolar (small field of view,  $\leq 8\text{cm}$ )

☐ CBCT scanner - craniofacial (large field of view,  $\geq 8\text{cm}$ )

☐ Medical CT scanner

☐ Other (please specify)

☐ Not sure

\* 31. Who operates the CT/CBCT scanner in your practice? Check all that apply.

☐ Myself

☐ Another dentist

☐ Medical radiation technologist

☐ Other (please specify)

☐ Not applicable

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Questions for Dentists - Frequency and Uses of CT/CBCT

\* 32. How often do you use CT/CBCT scans in your practice?

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Rarely
- ☐ Never

\* 33. For which groups of patients do you use CT/CBCT imaging? Check all that apply.

- ☐ Children (under 5 years)
- ☐ Children (5-18 years)
- ☐ Adults (over 18 years)

\* 34. For what purposes do you most commonly use CT/CBCT imaging? Check all that apply.

- ☐ Dental implant planning
- ☐ Impacted tooth assessment
- ☐ Endodontic imaging
- ☐ Temporomandibular joint (TMJ) assessment
- ☐ Orthodontic treatment planning
- ☐ Sinus evaluation
- ☐ Trauma/fracture assessment
- ☐ Detection of cysts or tumors
- ☐ Airway analysis
- ☐ Other (please specify)



\* 35. What factors most influence your decision whether to use CT/CBCT scanning? Select up to five.

- ☐ Availability of scanning
- ☐ Processing time
- ☐ Case complexity
- ☐ Diagnostic value compared to other imaging modalities
- ☐ Cost to patient
- ☐ Radiation dose
- ☐ Patient request
- ☐ Exposure to legal liability
- ☐ Other (please specify)

\* 36. For pediatric patients (under 18), how often do you order or take CT/CBCT scans?

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Rarely
- ☐ Never
- ☐ Not applicable

\* 37. For pediatric patients (under 18), for what purposes do you most commonly use CT/CBCT imaging? Check all that apply.

- ☐ Impacted tooth assessment
- ☐ Detection of cysts or tumors
- ☐ Trauma/fracture assessment
- ☐ Other (please specify)

- ☐ Not applicable

\* 38. Have you ever taken more than one CT/CBCT scan for a patient during the course of treatment?

- ☐ Yes, regularly
- ☐ Yes, occasionally
- ☐ Rarely
- ☐ Never

\* 39. If yes, what were the most common reasons for taking multiple scans? Check all that apply.

- ☐ Pre- and post- treatment assessment
- ☐ Orthodontic treatment monitoring
- ☐ Follow-up of pathology or healing
- ☐ Diagnostic uncertainty after initial scan
- ☐ Image quality issues
- ☐ Referral or specialist request
- ☐ Other (please specify)

- ☐ Not applicable

40. **Optional:** Please feel free to elaborate on any of your answers above or provide any other comments around how you decide to use CT/CBCT scans in your practice.

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Questions for Dentists - Ordering, Taking, Interpreting, and Reporting of CT/CBCT Scans

The *Dental CT Scanners* Standard of Practice describes four aspects related to use of CT/CBCT scans, which the prescribing dentist is responsible for: ordering, taking, interpreting, and reporting.

A brief description of these terms is as follows:

- **Prescribing:** Based on the performance of a clinical assessment, determining that a scan is clinically justified and there are no contraindications
- **Ordering:** Formally requesting the scan to be done
- **Taking:** Physically performing the scan on the patient
- **Interpreting:** Reviewing and analyzing the scan for any findings
- **Reporting:** Preparing the written documentation that reflects the interpretation of the scan

\* 41. Please indicate which aspects of ordering, taking, interpreting, and reporting of CT/CBCT scans that you or others perform:

	I perform this myself	I refer this out to a specific oral or medical radiologist	I use a third-party company	Depends on the case
Ordering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpreting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reporting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\* 42. Do you ever refer any CT/CBCT scans out-of-province for interpretation and/or reporting?

- ☐ Yes, within Canada
- ☐ Yes, outside of Canada
- ☐ Both
- ☐ No

43. **Optional:** Please feel free to elaborate on your answers above. For example, if you refer interpretation and/or reporting out-of-province, why? Do you refer to a general dentist or a dental specialist? If you've faced challenges with ordering, taking, interpreting, and/or reporting of CT/CBCT scans, what are they?

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Questions for Dentists - Risks and benefits of CT/CBCT scanning

**The College is interested in understanding how dentists understand and perceive the risks and benefits of CT/CBCT scanning in relation to other imaging modalities.**

\* 44. How would you rate the radiation risk of the following imaging modalities for patients?

	Very low risk	Low risk	Average risk	High risk	Very high risk	Not sure
Intraoral x-rays	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Panoramic x-rays	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CBCT (small field of view)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CBCT (large field of view)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical CT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

45. **Optional:** Please feel free to elaborate on your answers above related to the risks of various imaging modalities. Does your view on the risks of each modality influence which imaging you order, and if so, how?

\* 46. How would you rate the diagnostic value of the following imaging modalities for patients?

	Very low value	Low value	Average value	High value	Very high value	Not sure
Intraoral x-rays	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Panoramic x-rays	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CBCT (small field of view)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CBCT (large field of view)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical CT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

47. **Optional:** Please feel free to elaborate on your answers above related to the diagnostic value of various imaging modalities. Does your view on the diagnostic value of each modality influence which imaging you order, and if so, how?

\* 48. To what extent do you believe the use of CT/CBCT imaging is becoming the standard of care in dentistry for certain procedures?

- ☐ Completely
- ☐ To a great extent
- ☐ To a moderate extent
- ☐ To a small extent
- ☐ Not at all
- ☐ Not sure

49. **Optional:** Please feel free to elaborate on your answer above. For example, in which areas do you think that CT/CBCT imaging is or is becoming the standard of practice?

50. **Optional:** Please feel free to share any additional thoughts on the risks and benefits of CT/CBCT scanning.

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Questions for Dentists - Use of the Current *Dental CT Scanners* Standard

\* 51. How often do you refer to the *Dental CT Scanners* Standard of Practice to inform your practice?

- ☐ More frequently than five times a year
- ☐ Three to five times a year
- ☐ Once or twice a year
- ☐ Less than once a year
- ☐ Never

\* 52. Which topics in this document do you most commonly refer to? Check all that apply. You may review the Standard of Practice [here](#).

- ☐ Introduction - Dental CT Scanners and Field of View
- ☐ Guiding Principles for Dental CT Scans
- ☐ Professional Requirements - Educational Requirements
- ☐ Professional Requirements - On-site Training and Continuing Education
- ☐ Facility Requirements - Registration with RCDSO
- ☐ Facility Requirements - Installation
- ☐ Facility Requirements - Quality Assurance Program
- ☐ Clinical Requirements - Patient Referrals
- ☐ Clinical Requirements - Interpretation of Dental CT Scans
- ☐ Clinical Requirements - Reporting of Dental CT Scans
- ☐ Retention of Records
- ☐ Additional Resources and Reference Materials
- ☐ Not applicable

53. **Optional:** Please feel free to elaborate on your answers above. For instance, why do you refer to those specific topics? Which sections do you find the most helpful?

Preliminary Consultation: *Dental CT Scanners* Standard of Practice

Questions for Dentists - Dental CT Scanner Inspection Program

\* 54. To what extent are you familiar with the College's dental CT scanner inspection program?

- ☐ Extremely familiar
- ☐ Very familiar
- ☐ Moderately familiar
- ☐ Slightly familiar
- ☐ Not at all familiar

\* 55. How would you describe your experiences with the College's dental CT scanner inspection program?

- ☐ Very positive
- ☐ Somewhat positive
- ☐ Neutral (neither positive nor negative)
- ☐ Somewhat negative
- ☐ Very negative
- ☐ Not applicable

56. **Optional:** Please feel free to share any experiences you may have with the College's dental CT scanner inspection program, including any challenges and barriers.

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Evaluating the Current *Dental CT Scanners* Standard of Practice

**The following questions are applicable only to those who have read the *Dental CT Scanners* Standard of Practice in its entirety. If you indicate that you have not read the Standard of Practice, you will be advanced to the next section of the survey.**

**If you have not read the Standard of Practice and want to, you can review it [here](#).**

\* 57. Have you read the current *Dental CT Scanners* Standard of Practice?

☐ Yes

☐ No



## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Evaluating the Current *Dental CT Scanners* Standard of Practice

**The following questions will ask you about the *Dental CT Scanners* Standard of Practice as a whole.**

\* 58. Please indicate the extent to which you agree or disagree with the following statements.

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Not sure
The Standard of Practice is clear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Standard of Practice is accurate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Standard of Practice is comprehensive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Standard of Practice is reasonable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

59. **Optional:** Please feel free to elaborate on your answers above. For example, if you felt the Standard was not easy to understand, accurate, comprehensive, or reasonable, why? How could it be improved?

\* 60. Do you think the Standard of Practice includes any unnecessary information?

☐ No

☐ Yes (please specify what and why)

☐ Not sure

\* 61. To what extent do you think that the current Standard of Practice supports dentists in providing safe and effective oral health care to patients in Ontario?

☐ Completely

☐ To a great extent

☐ To a moderate extent

☐ To a small extent

☐ Not at all

☐ Not sure

62. **Optional:** Please feel free to elaborate on your answer above. If you don't think that the current Standard of Practice supports dentists in providing safe and effective oral health care, why not?

Preliminary Consultation: *Dental CT Scanners* Standard of Practice

Final Feedback

63. **Optional:** Please share with us any feedback you have not already provided related to your experience with CT/CBCT scanners.

A large, empty rectangular box with a thin black border, intended for the user to provide feedback. A small cursor icon is visible in the bottom right corner of the box.

Preliminary Consultation: *Dental CT Scanners* Standard of Practice

Survey Evaluation

64. **Optional:** Based on your experience completing this survey, do you have any feedback to help improve this survey or future RCDSO surveys?

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## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Demographics

**We welcome you to voluntarily share some demographic information about yourself. The RCDSO strives to protect the public interest while using processes that achieve meaningful equity, diversity, inclusion, and accessibility across all of our regulatory programs and projects.**

**Therefore, we are collecting demographic information to help us identify whether our consultation process is inclusive, and whether we are receiving a diversity of perspectives.**

**Please note that any demographic information that you provide through the survey will be anonymous, and your responses will be stored securely. Your demographic information will be aggregated for internal/external reporting purposes and will not be linked to you.**

\* 65. Would you like to complete these demographic questions?

☐ Yes

☐ No

## Preliminary Consultation: *Dental CT Scanners* Standard of Practice

### Demographics - Continued

\* 66. What is the location of your primary residence?

- ☐ Ontario
- ☐ Outside of Canada
- ☐ Another province or territory in Canada (please specify)

- ☐ I prefer not to answer

\* 67. Describe the general area where your primary residence is located?

- ☐ Extra-large urban area (population of 500,000 or more)
- ☐ Large urban area (population between 100,000 and 499,999)
- ☐ Medium urban area (population between 30,000 and 99,999)
- ☐ Small urban area (population between 1,000 and 29,999)
- ☐ Rural and/or remote (population less than 1,000)
- ☐ Other (please specify)

- ☐ I prefer not to answer

\* 68. How old are you?

- ☐ 19 years old or under
- ☐ 20-29 years old
- ☐ 30-39 years old
- ☐ 40-49 years old
- ☐ 50-59 years old
- ☐ 60-69 years old
- ☐ 70+ years old
- ☐ I prefer not to answer

\* 69. What is the highest level of education you have completed?

- ☐ Some high school
- ☐ High school
- ☐ College degree/diploma
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Ph.D. or higher
- ☐ Dental degree (BDS/DDS/DMD or higher)
- ☐ Other professional degree (e.g., law, medicine, engineering)
- ☐ Trade school
- ☐ Other (please specify)

- ☐ I prefer not to answer

\* 70. Please indicate which of the following terms best describes your gender identity. Please select all that apply (options are listed in alphabetical order - click [here](#) for definitions of the following terms):

- ☐ Genderqueer
- ☐ Man
- ☐ Nonbinary
- ☐ Questioning
- ☐ Two-Spirit
- ☐ Woman
- ☐ Other (please specify)

- ☐ I prefer not to answer

\* 71. Do you identify as trans/transgender or consider yourself to be a part of a trans/transgender community?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ I prefer not to answer

\* 72. Please indicate which of the following terms best describe your sexual orientation.

Check as many as apply (options are in alphabetical order).

- ☐ Asexual
- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Pansexual
- ☐ Queer
- ☐ Questioning
- ☐ Two-Spirit
- ☐ Other (please specify)
- ☐ I prefer not to answer

\* 73. Do you identify as an Indigenous person? Please select all that apply.

- ☐ Yes, First Nations (Status and Non-Status)
- ☐ Yes, Métis
- ☐ Yes, Inuit
- ☐ Yes, an Indigenous person from outside of Canada
- ☐ No
- ☐ Yes, Other (please specify)

- ☐ I prefer not to answer

74. Optional: Please describe your ethnicity in whatever terms are most meaningful to you.

\* 75. Do you speak French?

- ☐ Yes, I am fluent.
- ☐ Yes, with limited fluency.
- ☐ No
- ☐ I prefer not to answer



\* 76. What is your faith, religion, and/or spiritual affiliation? Please select all that apply.

- ☐ Agnostic
- ☐ Atheist
- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Indigenous spirituality
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ No religion or spiritual affiliation
- ☐ Other (please specify)

- ☐ I prefer not to answer

\* 77. Do you identify as a person with a disability or disabilities?

- ☐ Yes
- ☐ No
- ☐ Sometimes, depending on the context
- ☐ I prefer not to answer

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### Demographics (Disability Type)

\* 78. Describe your disability. Please select all that apply (options are listed in alphabetical order).

- ☐ Auditory
- ☐ Cognitive (memory, focus, attention, consciousness, etc.)
- ☐ Dexterity (related to use of fingers, hands, etc.)
- ☐ Developmental
- ☐ Fatigue-related
- ☐ Flexibility
- ☐ Gastrointestinal
- ☐ Intellectual (e.g., Learning)
- ☐ Invisible
- ☐ Mobility (movement, balance, coordination, etc.)
- ☐ Mental Health-related
- ☐ Pain-related
- ☐ Sight
- ☐ Speech
- ☐ Urinary
- ☐ Other (please specify)

- ☐ I prefer not to answer

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End of Survey

**Thank you for participating in our survey!**