Henry M. Goldman School of Dental Medicine

CBCT/3D IMAGING
REFERRAL FORM

PATIENT INFORMATION:

Name: _____ D.O.B.: _____ Male: _____ Female: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Telephone: _____ Email: _____

Today's Date: _____ Appointment Date/Time: _____ Consult Date: _____

REFERRING DOCTOR:

Name: _____ Address: _____

Telephone: _____ Email: _____

SPECIFY EXAM:

☐ Implant Mandible (specify site) _____ ☐ Implant Maxilla (specify site) _____

☐ CBCT Panoramic View ☐ Orthodontic Assessment ☐ Impaction (specify site) _____

☐ Endodontic Assessment ☐ Sinus Assessment ☐ Airway Assessment ☐ TMJ

☐ 3-D ☐ Entire Maxillofacial Region ☐ Other _____

IMAGE DATA REQUEST:

☐ Prints of region of interest ☐ CD with DICOM file

SPECIAL INSTRUCTIONS:

☐ Patient in Occlusion ☐ Mandibular and Maxillary Separate ☐ Surgical Guide

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