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:

☐ Mandibular Scan ☐ Maxillary Scan

☐ Full Dental Arch Scan ☐ TMJ Scan

SPECIAL REQUESTS OR ADDITIONAL REQUESTS:

☐ Scan Guide ☐ Simplant Reconstruction

IMAGE DATA REQUEST:

☐ CD with DICOM file ☐ Surgical Guide

SPECIAL INSTRUCTIONS:

_____

_____

_____

Oral Diagnosis and Radiology
100 East Newton Street, G-102
Boston, MA 02118

For appointments or questions: 617-638-4700, option #2
Fax: 617-638-7639