BU –enry M. Goldman School of Dental Medicine

CBCT/3D IMAGING
REFERRAL FORM

PATIENT INFORMATION:

Name:_____ **D.O.B:** _____

Patient Chart #:_____ **Date of Referral:** _____

REFERRING DOCTOR:

Resident Name:_____ **Dept**: _____

Surgical Faculty Name: _____

Surgical Faculty Signature: _____

Restorative Faculty Name: _____

Restorative Faculty Signature: _____

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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