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: 617-358-8360
Fax: 617-358-0507