

# CONE-BEAM CT REFERRAL FORM

TO: Oral and Maxillofacial Radiology Services, 467 Pennsylvania Ave., Suite 108, Fort Washington, PA 19034

PLEASE FAX FORM TO: 215-643-1149, CALL FOR APPOINTMENTS: 215-643-5881

## PATIENT DETAILS (MUST BE COMPLETED)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Phone: (Work): \_\_\_\_\_ Phone: (home/cell): \_\_\_\_\_

## REFERRING PRACTITIONER

From: Dr. \_\_\_\_\_ TEL: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ PA \_\_\_\_\_ ZIP \_\_\_\_\_

Email: \_\_\_\_\_ FAX: \_\_\_\_\_

Relevant Clinical / Dental History: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / 20\_\_\_\_

## SERVICES REQUESTED

### IMPLANT:

Arch:  Maxilla  Mandible  Both

Format:  Entire arch(s)  Specific Region: \_\_\_\_\_

### THIRD MOLAR:

Arch  Maxilla  Mandible  Both

Format:  IAC identification

TMJ:  Closed only  Open and closed  Closed with splint in

PATHOLOGY: Arch:  Maxilla  Mandible  Both

Location / Working Dx: \_\_\_\_\_

OTHER:  Orthodontic analysis  Paranasal Sinus  Airway  3D Impacted Teeth

DELIVERY:  Email report/images as PDF  Hardcopy report/selected images

Fax report/send images  CD – iCATVision viewing software  DICOM data

**SERVICE FEES: \$300 (I-Cat Imaging Scan and Radiology Report) Payable To "Viewpoint"**