

DIAGNOSTIC IMAGING REFERRAL FORM

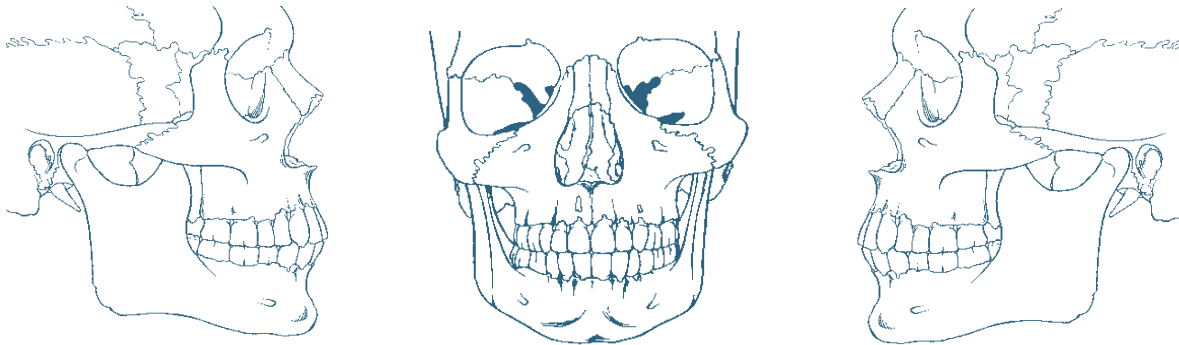
Patient Name: _____ Telephone : _____
 Date of Birth: _____ Appt. Date: _____
 Referring Dr: _____ Appt. Time: _____
 Next appointment with referring Dr: _____

3-D Cone Beam Volumetric Imaging

This service includes one CBVI imaging session, image file complete with viewer and a printed set of reformatted images. (Turnaround time is 3 business days after the date of scan. Please call our office to make special arrangements for RUSH scans).

- | | | | |
|-----------------------------------|---|--|-------------------------------------|
| <input type="checkbox"/> Implants | <input type="checkbox"/> Dental Impaction | <input type="checkbox"/> Airway Assessment | <input type="checkbox"/> Sinus Exam |
| <input type="checkbox"/> TMJ Exam | <input type="checkbox"/> Oral Pathology | <input type="checkbox"/> Endodontics | <input type="checkbox"/> Other |

Please circle Region of Interest (ROI)



Other Services

- Orthodontic Records: Digital photographs, volume views of skull and dentition, panoramic radiograph, lateral cephalogram with digital tracing
 Steiner Jarabak Ricketts Sasouni McNamara Other _____
- 3-D Segmentation of specific structures of interest (e.g. airway reconstruction, impacted teeth)
- Panoramic Intraoral Radiographs
- Radiographic Interpretive Report Additional Printed Reports

Special Instructions: _____

Dr. (print name): _____ Date: _____

Signature: _____

Orbit Imaging Center Redlands

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*see over for map

