

CONE-BEAM CT REFERRAL FORM

TO: Oral and Maxillofacial Radiology Services, 467 Pennsylvania Ave., Suite 201, Ft. 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 – iCAT Vision viewing software DICOM data
 Simplant Conversion (Additional Charge) NobelGuide Conversion (Additional Charge)

SERVICE FEES: \$300 (I-Cat Imaging Scan and Radiology Report) Payable To "Viewpoint"
Other Services: NobelGuide and Simplant Conversion. Please call for pricing.