



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:

- 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 Dicom Data Only Other _____
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IMAGE DATA REQUEST:

- Prints of region of interest CD with DICOM file
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SPECIAL INSTRUCTIONS:

- Patient in Occlusion Mandibular and Maxillary Separate Surgical Guide
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