THE Maxillofacial Surgery CENTER

Spencer G. Wilson, DDS, PC
Diplomate, American Board of Oral and Maxillofacial Surgery

CT IMAGING REFERRAL FORM

DATE: _____

PATIENT NAME: _____ DATE OF IMAGING APPT: _____

DATE OF BIRTH: _____ APPT. TIME: _____

Please call to schedule an appointment. Please bring this referral paper with you.

CT Imaging Services, including cone beam imaging, means computerized tomographic imaging with no contrast, which is limited to the head and neck. Services include CT Imaging, a consultative report by an Oral and Maxillofacial Radiologist or Medical Radiologist, and mailing the images to the referring doctor.

3D Conebeam CT Scan

- ❑ ORTHODONTICS
  - ❑ 3-D Virtual Study Models
- ❑ IMPLANT
  - ❑ Maxilla
  - ❑ Mandible
  - ❑ Dual Arch
- ❑ TMJ STUDY
  - ❑ TMJ Limited
  - ❑ TMJ Complete
- ❑ IMPACTION ANALYSIS
- ❑ SINUS ANALYSIS
- ❑ AIRWAY ANALYSIS
- ❑ ORAL PATHOLOGY
- ❑ ENDODONTICS
- ❑ SUPERNUMERARY

2D Digital Radiographic Imaging

- ❑ PANORAMIC

Digital Photography

- ❑ INTRA ORAL & EXTRA ORAL DIGITAL PHOTO SERIES

Radiologist Report

- ❑ AIRWAY EVALUATION
- ❑ IMPACTION/LOCALIZATION
- ❑ IMPLANT
- ❑ ORTHODONTIC EVALUATION
- ❑ ORAL PATHOLOGY
- ❑ SINUS EVALUATION
- ❑ TMJ

SPECIAL INSTRUCTIONS: _____

_____

_____

_____

REFERRING DOCTOR NAME: _____ PHONE: _____

DR. SIGNATURE: _____

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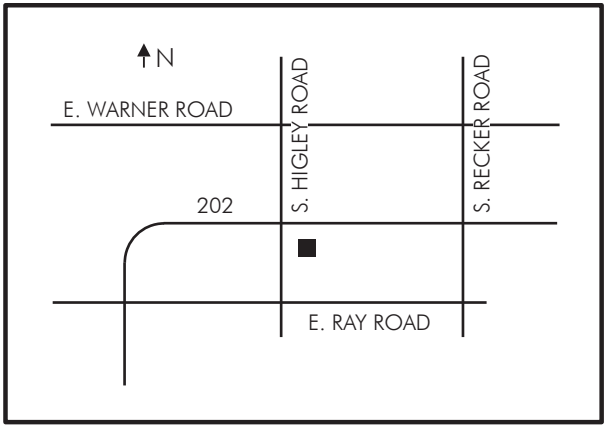

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