REFERRAL FORM FOR CBCT SCAN – NUVO DENTAL (CR Diener Professional Corporation)

Date: _____

Ordering Dentist

Name: Practitioner Number:

Address:

Phone: Fax: E-mail:

Acquiring Dentist

Name: Practitioner Number:

Address:

Phone: Fax: E-mail:

Interpreting and Reporting Dentist

Name: Practitioner Number:

Address:

Phone: Fax: E-mail:

Patient Information:

Name: Date of Birth:

Age: Sex:

Address:

Phone: Cell: E-mail:

Brief Medical/Surgical History:

Summary of Justification for CBCT Scan:

(Case history, provisional diagnosis, proposed treatment, anatomic area to be scanned)

_____

Signature of Dentist