PLEASE BRING THIS REFERRAL FORM TO YOUR APPOINTMENT

SOUTHERN COLORADO ORAL & FACIAL SURGERY

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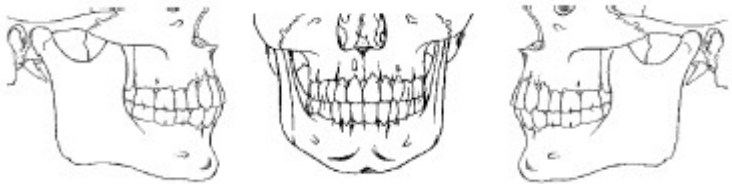
Patient Name _____ Date of Birth _____
Ordering Doctor _____ Today's Date _____

Maxillofacial CT Image *(please check below – arch or arches requested)*
☐ Maxillary Arch ☐ Mandibular Arch ☐ Both Arches

Reason for Scan: _____

Please Circle the Region of Interest (ROI)



Comments: _____
_____
_____
_____
_____

Field of View (Height x Diameter)
☐ Small (5x5cm)
☐ Medium A (8.5x5cm)
☐ Medium B (8.5x8.5cm)
☐ Large (10x12cm)

Level of Detail (Higher detail = longer exposure)
☐ Course
☐ Medium
☐ Fine

Images returned to referring doctor in the following format:
☐ CD by mail ☐ CD sent with patient
☐ Secured download link (large files) – Email: _____

Please check one:
☐ Scan will be read by ordering doctor
☐ Radiographic interpretation requested (add'l fee)

By signing below, I request Southern Colorado Oral & Facial Surgery and its associates to acquire the images and have obtained authorization from the patient for these procedures.

Dr. (Print Name) _____ Signature _____ Date _____

PATIENT INFORMATION

- Please give a 24 hour notice if you need to cancel your appointment
- All images are delivered to the referring doctor unless prior arrangements have been made
- Fees for images are payable at the time of your appointment. Contact your insurance carried for coverage information.
- If you are pregnant, or think you may be pregnant, contact your physician before scheduling your appointment.