

## Cone Beam CT Referral Form

### Ordered By

|                |   |
|----------------|---|
| Doctor Name    |   |
| Practice Name  |   |
| Street Address | , |
| Phone Number   |   |
| Fax Number     |   |
| Email          |   |

### Patient Information

|                                   |  |
|-----------------------------------|--|
| Patient Name                      |  |
| Patient Phone                     |  |
| Date of Birth                     |  |
| Gender                            |  |
| Ethnicity                         |  |
| Race                              |  |
| Dental History and Medical Alerts |  |

### Options

|                     |  |
|---------------------|--|
| Field of View       |  |
| Reasons for Scan    |  |
| Scan Options        |  |
| Field of View       |  |
| Additional Comments |  |