South Bay IMAGING & Wellness Center

3D CONE BEAM CT SCAN

Referral Form

PHONE: (310) 848-1404

FAX: (310) 848-1403

www.sbicenter.com

Referring Office: (**ALL** information must be completed to avoid referred patient wait time.)

Name of Office: _____ **Doctor Name:** _____

Clinic Name & Address: _____ **Signature of Doctor:** _____

_____ **Date:** _____

_____ **Primary Contact #:** _____

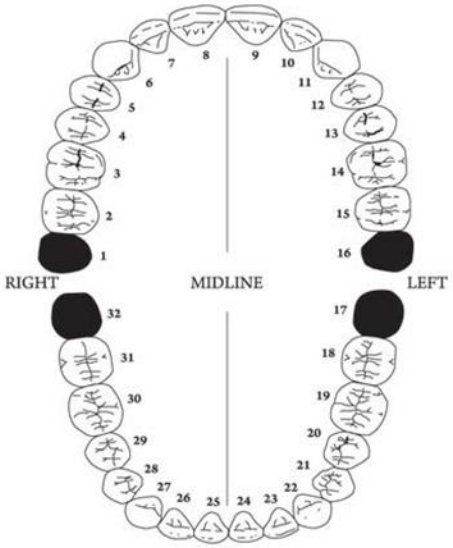
Patient Information: (MUST bring valid form of identification, referral form and the payment is due at the time services are rendered.)

Patient Name: _____ **Date of Birth:** _____

Date of Referral: _____ **Next Visit with Referring Office:** _____

Imaging Request:

- ☐ Maxilla & Mandible
- ☐ Maxilla
- ☐ Mandible
- ☐ Panograph
- ☐ Scan with Surgical Guide (Please provide specifics)
- ☐ Orthodontic Survey (Photos, Tracing, Ceph Images, Panograph)
- ☐ Limited Orthodontic Survey (Without Photos)
- ☐ Final/Progress Orthodontic Records (Photos, Panograph)
- ☐ Invisalign Records (Photos, Panograph)



(Most Images are taken with the following settings: mAs: 20.27 KVP: 120 Aq. Time: 14.7 Seconds; Quantum IQ filter used unless being sent for radiology report. Please specify is any changes are needed)

Special Instructions: _____

_____

11968 Aviation Blvd.

Inglewood, CA 90304

Report Request:

- ☐ **Basic Radiology Report**
- ☐ **Analytical Report (Specific Area)**
- ☐ **CT Scan Slice Study (Area MUST be indicated on upper right image)**

Additional Services:

- ☐ **Online Email** (Must provide email every time)

Email: _____

- ☐ **Additional CD (Charges Apply)**
- ☐ **US Postal Services (Please spec-**

Patient has given consent for SBI Center to acquire all images requested above by referring doctor.

Patient Signature: _____ **Date:** _____

A radiology report is considered mandatory for all images taken unless dictated by the referring doctor and/or referred patient. A radiology report consists of a licensed radiologist interpreting the images taken for any abnormalities and/or pathology. Patient understands that by declining the radiology report they are liable for any findings in the images and relieves SBI Center from any future liabilities. If client declines:

Please Initial: _____ **Date:** _____