3D Oral & Maxillofacial Imaging Center, LLC
11125 Rockville Pike #211, North Bethesda, MD 20852 Phone: 240-221-0797 Fax: 240-560-5358 info@3domi.net

Referral for Cone Beam CT Imaging

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

Referring office address: _____

Referring office phone # & Email: _____

Relevant History: _____

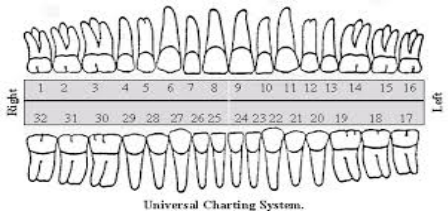
Please circle the area to be scanned:

3D: Focused(5x5cm)* Maxilla(10x5cm) Mandible(10x5cm) Max & Mand(8x8cm)

Max/ Mand/Max. Sinuses(10x10cm) Full Head 17x11cm or 17x13.5cm TMJ(17x6cm)

for field of view 5x5cm up to 3 adjacent teeth, specify the location below:

2D: Panoramic



Special Instructions:_____

Diagnostic Objectives. Please circle:

Implant (w/ radiographic stent? yes no) Endodontic Impacted tooth Orthodontic TMJ Airway

ICD-9/Diagnosis _____

Others _____

CD includes Viewing Software & Dicom files of scan: ☐ Mail to Doctor ☐ Patient ☐ Email(Dropbox or GoogleDrive)

Please check any applicable: ☐ Radiologist Review *☐Rush ☐USB Drive is preferred*

☐ Scan to be shared with: _____

Invoice: ☐Doctor ☐Patient

We, 3D Oral & Maxillofacial Imaging Center, LLC, are not involved in the diagnosis or the treatment plan/procedure & do not provide the interpretation of the CBCT images. If the Radiologist Review is not requested, it is agreed that the Referring Doctor comprehensively reviews the Cone Beam CT scanned images and determines if a review by a board certified oral & maxillofacial radiologist is necessary. The report with findings, the key images with nerve tracing and measurements, if provided, will require the review & follow-up care of the patient by the Referring Doctor.

Referring Doctor Name _____ **Phone** _____

_____ _____

Signature of Referring Doctor **License #** **Date**