CONE BEAM CT ORDER FORM

(FOR REFERRING CLINICIANS OUTSIDE OF OSU COLLEGE OF DENTISTRY)

PATIENT INFORMATION DATE OF ORDER: _____

NAME: _____ DOB: _____

MAILING ADDRESS: _____

PHONE: (HOME) _____ PHONE: (CELL/WORK) _____

REFERRING CLINICIAN INFORMATION

NAME: _____ LICENSE STATE & NO.: _____

PHONE: _____ FAX: _____ EMAIL: _____

RELEVANT MEDICAL, DENTAL AND CLINICAL HISTORY:

_____

_____

_____ ICD9 CODE(S): (IF APPLICABLE) _____

SIGNATURE: _____ DATE: _____

SERVICES REQUESTED

IMPLANT: MAXILLA ☐ MANDIBLE ☐ BOTH ☐ SPECIFIC SITE(S)_____ BONE GRAFT: ☐ SITE_____

IMAGING STENT PROVIDED: ☐ Tx PLANNING SOFTWARE_____

PATHOSIS: MAXILLA ☐ MANDIBLE ☐ BOTH ☐ OTHER_____

LOCATION AND WORKING DIAGNOSIS_____

TMJ: CLOSED ONLY ☐ OPEN AND CLOSED ☐ CLOSED WITH SPLINT ☐

THIRD MOLAR: MAXILLA ☐ MANDIBLE ☐ BOTH ☐ SPECIFIC SITE(S)_____

MISC.: ORTHODONTIC ☐ ENDODONTIC ☐ PARANASAL SINUSES ☐ AIRWAY ☐

ANATOMICAL MODELING ☐ OTHER (SPECIFY DIAGNOSTIC NEED)_____

BILLING INFORMATION AND REPORT DELIVERY

RESPONSIBLE PARTY: BILL TO REFERRING CLINICIAN: ☐ _____ PATIENT ☐ _____

REPORT: HARDCOPY OF REPORT & SELECTED IMAGES + SCAN ON CD ☐ FAX REPORT ☐ EMAIL REPORT ☐

ADDITIONAL COMMENTS

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