Arden Park Dental - Cone Beam CT Report for Referral

(Information provided by Referring Dentist)

Referring Dentist Name: _____
_____
(please provide other dentist's names that will be receiving a copy of the report)

Referring Office Name: _____

Patient's Name: _____
Address: _____
Date of Birth: _____ (dd/mm/yyyy)

Type of CT Scan Requested: _____
Special Instructions:
_____
_____

Small Field CBCT area scanned (Kodak 9000 3D reformatted with CS 3D imaging software):

- ❑ Maxilla: _____
- ❑ Mandible: _____
- ❑ TMJ: _____
- ❑ Other: _____

Reason for requested CBCT:

- ❑ Implant(s)
- ❑ Impacted Tooth/Teeth
- ❑ Inferior Alveolar Nerve Localization
- ❑ Lesion/Pathology
- ❑ Sinus
- ❑ TMJ
- ❑ Other: _____

Limitations/technical factors:

- ❑ None
- ❑ Patient Movement
- ❑ Metallic artifact
- ❑ Other: _____

Additional radiographs/images:

- ❑ None
- ❑ Submitted: _____
- ❑ Taken Type: _____
  Reason: _____

(internal office use only)

Prescribing Dentist: Dr. _____

Date of CDCT performed: _____ (dd/mm/yyyy)

Date of Report: _____ (dd/mm/yyyy)

Pertinent History:

Findings:

Comparative information (if any):

Conclusion:

Working Diagnosis: _____

Differential Diagnosis includes: _____

Correlation to clinical findings is recommended.

Additional Suggestions/Recommendations:

_____

Name and Signature of Reporting Dentist