CONE BEAM CT SCAN REFERRAL INFORMATION FORM

ADVANCED AESTHETIC CENTER FOR ORAL AND MAXILLOFACIAL SURGERY (AACOMS)
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From Doctor: _____ ***Date:*** _____

Doctor's Telephone: _____ ***Doctor's EMail:*** _____

Name of Patient: _____ ***Patient's D.O.B.:*** _____

Indications for Scan:

❒ RULE OUT PATHOLOGY ❒ ORTHODONTIC CONCERNS ❒ TMJ EVALUATION
❒ SINUS(ES) EVALUATION ❒ IMPLANT PLANNING ❒ EVALUATE EXISTING IMPLANT(S)
❒ TRAUMA ❒ EVALUATE POSITION OF INFERIOR ALVEOLAR NERVE (IAN)

Relevant Patient History:

PATIENT IS A _____ YEAR OLD ❒ FEMALE ❒ MALE WITH _____

_____

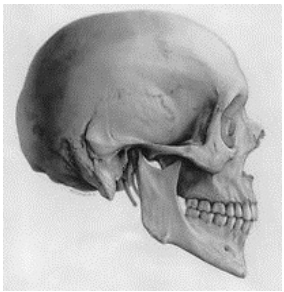
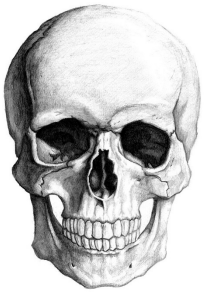
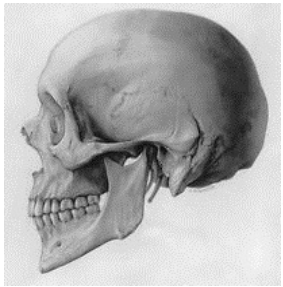
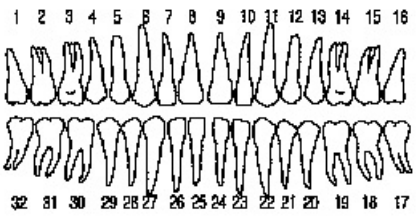
❒ SYMPTOMS OF _____

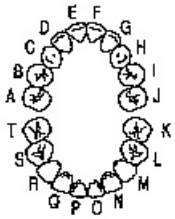
_____

❒ NO SYMPTOMS.

Region of Interest (ROI) - Please Check and Circle Area:

❒ MAXILLA ❒ MANDIBLE ❒ TOOTH/TEETH AREA(S) #: _____



Comments and Special Requests:

❒ PLEASE EVALUATE ❒ FOR SUPERNUMERARY TOOTH/TEETH ❒ AND ROOT(S) MORPHOLOGY
❒ PLEASE EVALUATE PATHOLOGY:

_____

_____

❒ PLEASE QUANTIFY/IDENTIFY ❒ UPPER ❒ LOWER ❒ LEFT ❒ RIGHT ❒ ANTERIOR ❒ POSTERIOR BONE LOSS AND BONE AVAILABLE WITH MEASUREMENTS OVER ALL AREAS THAT HAVE NO TEETH.

❒ PLEASE MAP ❒ LEFT ❒ RIGHT I.A.N. AND ANY INTERRUPTIONS OF THE I.A.N. CANAL, AND IDENTIFY ITS LOCATION IN RELATION TO THE ROOTS.

❒ PLEASE QUANTIFY/IDENTIFY ❒ EXTENT OF ❒ THE AREA ❒ PATHOLOGY ❒ THE CYST IN THE R.O.I.

❒ PROVIDE AXIAL AND CORONAL VIEWS OF R.O.I.

❒ PROVIDE 3D VOLUME RENDERING OF R.O.I.

Disclaimer: The Referring Doctor understands and agrees that Dr. Marcos Díaz and/or AACOMS is not responsible for providing any interpretation/diagnosis/treatment recommendations of the Cone Beam CT scan images. Hereby, the Referring Doctor waives, releases and discharges Dr. Marcos Díaz and AACOMS from any and all claims relating to the interpretation, diagnosis and treatment of set forth patient.

Doctor Authorization Signature: _____