Arden Park Dental - Cone Beam CT Report for Referral

(Information provided by Referring Dentist)

Referring Dentist Name: ____

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(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:

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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:

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Name and Signature of Reporting Dentist