

## CT IMAGING SERVICES REFERRAL FORM

Patient Name \_\_\_\_\_ Date of Imaging Appt \_\_\_\_\_

Date of Birth \_\_\_\_\_ Appointment Time \_\_\_\_\_

CT Imaging Service, including cone beam imaging, means computerized tomographic imaging with no contrast which is limited to the head and neck. Services include CT Imaging, a consultative report by an Oral and Maxillofacial Radiologist or Medical Radiologist, and the mailing of the images to the referring doctor. Vancouver Oral Surgery Group only provides the scan and DOES NOT take any responsibility for the reading of the image.

Reason for Imaging Request:

\_\_\_\_ Implants    \_\_\_\_ TMJ    \_\_\_\_ Sinus    \_\_\_\_ Dental Alveolar    \_\_\_\_ Airway Assessment

\_\_\_\_ Maxillofacial Trauma            \_\_\_\_ Maxillofacial Pathology

\_\_\_\_ Other (Please Explain) \_\_\_\_\_

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Referring Doctor's Signature (REQUIRED): \_\_\_\_\_

Print Doctor's Name \_\_\_\_\_ Date \_\_\_\_\_

Cost of the CT Image is the patient's responsibility and is due IN FULL on date of appointment. The fee including the scan and the radiologist's services is \$335.00

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