

**CONE BEAM CT IMAGING SERVICES REFERRAL FORM**

**WATERFORD**  
 4250 Pontiac Lake Road • Suite B  
 Waterford, Michigan 48328  
 tel 248.674.0303  
 fax 248.674.2947

**BRIGHTON**  
 9880 E. Grand River • Suite 150  
 Brighton, Michigan 48116  
 tel 810.227.2626  
 fax 810.227.8532

DATE: \_\_\_\_\_  
 PATIENT NAME: \_\_\_\_\_  
 PATIENT DOB: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 REFERRING DOCTOR'S NAME: \_\_\_\_\_  
 PHONE: \_\_\_\_\_

**REGION OF INTEREST:**

TOOTH NUMBER(S): \_\_\_\_\_  MAXILLA  MANDIBLE

**REASON FOR IMAGING REQUEST:**

- MAXILLOFACIAL PATHOLOGY\*\*
- ALVEOLAR
- TMJ STUDY\*\*
- AIRWAY ASSESSMENT\*\*
- ORTHODONTIC
- IMPLANT
- SINUS\*\*
- EAR CANAL\*\*
- OTHER \_\_\_\_\_

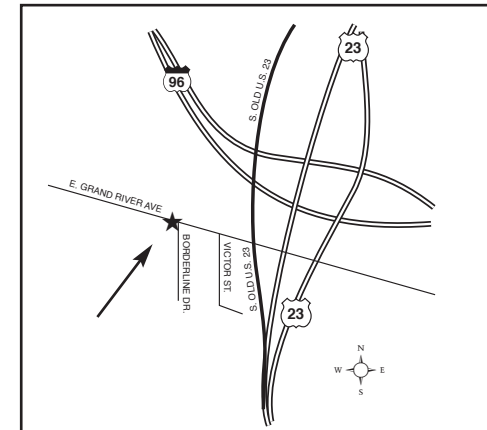
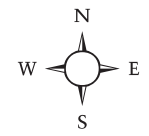
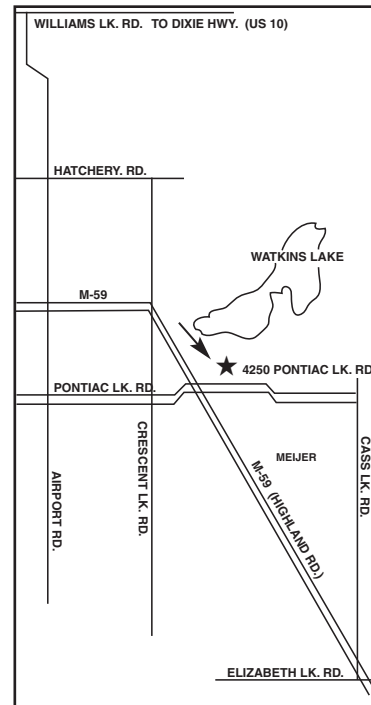
\*\* DIAGNOSTIC CODE: \_\_\_\_\_ \*\* AUTHORIZATION #: \_\_\_\_\_

SPECIAL INSTRUCTIONS: \_\_\_\_\_

**PLEASE BRING THIS FORM TO YOUR APPOINTMENT**

REFERRING DOCTOR'S SIGNATURE (REQUIRED) \_\_\_\_\_ DATE \_\_\_\_\_

*CONE BEAM IMAGING SERVICES MEANS COMPUTERIZED TOMOGRAPHIC IMAGING WITH NO CONTRAST WHICH IS LIMITED TO THE HEAD AND NECK. REFERRING OFFICES WILL RECEIVE A CONSULTATIVE REPORT BY A BOARD CERTIFIED RADIOLOGIST AND A MAILING OF THE IMAGES.*



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