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Cone Beam CT Referral Form

Date

Appointments are made through Dental Faculty Associates (DFA) (734-764-3155). Patient should report to DFA (Room 1340, first floor, School of Dentistry) 30 minutes before appointment to register. Registration material will be sent to patient in advance if there is enough time before appointment.

Patient Information

Ordered By

| Doctor Nama: | | Detient Name | | | |
|--|----------------------------|-------------------------------------|---|-------|--|
| Doctor Name: | | Patient Name: | | | |
| Practice Name: | | Phone: | | | |
| Address: | | DOB: | | | |
| State/Province: | | Gender: | | | |
| Zip/Postal Code: | | Ethnicity: | | | |
| Phone: | | | | | |
| Fax: | | Dental History & Medical Alerts: | | | |
| Email: | | | | | |
| Region to be Scanned | | Reason(s) fo | Reason(s) for the Scan | | |
| Maxilla | Mandible Both j | aws Implant(s) |) Sinus | s(es) | |
| UR | UAnt UL | Impaction | n Traur | na | |
| LR | LAnt LL | TMJ | Surge | ery | |
| TMJ: Clo | osed mouth Open mouth | Other (ple | ease explain) 🗌 Patho | ology | |
| Full head (please | explain) | ROI / Impla | nt site (s) | | |
| | | | | | |
| | | | | | |
| Scop Options | | | | | |
| Scan Options | | Image Data | Output | | |
| With imaging ster | | Report by | Report by email DICOM files | | |
| Specific request (please explain) Separate lip / cheek | | eek | Specific request (please explain) Scan + viewer | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Comments | | | | | |
| | | | | | |
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| | | | | | |
| | Health Hx. reviewed by: | | Patient UM Reg # | | |
| For internal use only | Referral Form reviewed by: | | Date: | | |
| | Scanning protocol: | | Time: | | |

Please email CBCT-related questions to benavid@umich.edu or sinra@umich.edu