54 S. Medical Park Drive
Fishersville, VA 22939
540-886-2956
Fax 540-886-2284

CT IMAGING SERVICES REFERRAL FORM

Patient Name: ________________________ Date of Imaging Appt: _____________

Date of Birth: ________________________ Appointment Time: _______________

CT Imaging Services, 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.

Reason for Imaging Request:

____ Implants ____ TMJ ____ Sinus ____ Dental Alveolar

____ Airway Assessment ____ Maxillofacial Pathology ____ Maxillofacial Trauma

____ Consultation Requested

____ Other *(Please Describe)*____

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Referring Doctor's Signature *(Required)*: ________________________________

Print Name: ___________________________________ Date: _________________