UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

School of Dentistry, Faculty Practice
650 West Baltimore Street Baltimore, MD 21201
Office Phone: (410) 706-7961
Fax: (410) 706-0309

DENTAL CONE BEAM CT REFERRAL FORM

REFERRING DOCTOR INFORMATION:	
Name:	**Mailing Address:**
Office Contact:	
Email:	
Telephone #:	
PATIENT INFORMATION:	
Name:	**Mailing Address:**
Phone:	
Date of Birth:	
Gender: M ☐ F ☐ Transgender ☐	
SIGNIFICANT MEDICAL HISTORY:	
SIGNIFICANT DENTAL HISTORY:	
REASON FOR CBCT STUDY:	
Pathosis evaluation: Y ☐ N ☐	**Other:**
Implant evaluation: (Stent provided?) Y ☐ N ☐	
TMJ Study: Y ☐ N ☐	
IMAGE REQUEST:	
Other: ☐ 16x12 W/ nose - Large Maxillofacial FOV	**Paranasal sinuses, TMJs, extensive pathology/trauma**
☐ 12x10 Small Maxillofacial FOV w/or without nose	**Implant guided cases, 3rd molar evaluation**
☐ 12x5 Single Jaw, Maxillary or Mandible, Low res	**Implant without guide, localized pathology, etc**
☐ 5x5 Endo High Resolution	**Endo evaluation**
☐ 10x10 High Resolution	**Endo evaluation for multiple teeth in one arch**
Other volume sizes are available, see FOV chart	**Custom size**

Signature of referring dentist:

The radiology report will be e-mailed via secure e-mail to the e-mail address you provide above.
Format of CBCT: Carestream3D View ☐ DICOM ☐ Send disc w/patient ☐ Electronic copy ☐

TO SCHEDULE, CALL: (410)706-7961; Please email this form to JRoberts1@umaryland.edu