CIC

Craniofacial Imaging Center
at CWRU School of Dental Medicine

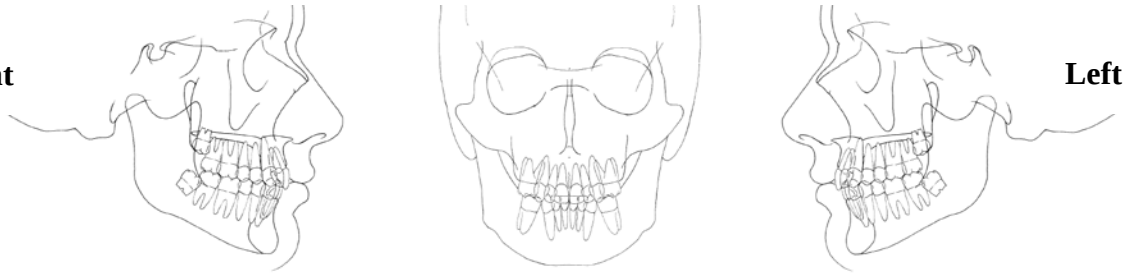
Patient Name_____ **D.O.B.:** _____

Note to Patients: Please bring this referral form with you. Payment is due when services are rendered.
Note: The CIC is not responsible for image interpretation, reading or findings. The diagnosis and treatment planning is the responsibility of the referring doctor.

3D Volumetric Imaging - Primary reason for the Imaging Request:

O **Implants**	O **NobelGuide™**	O **Microscrews (TAD)**	O **Airway Study**	O **Craniofacial Study**
O **Pathologic Investigation**	O **Impacted Tooth Location**	O **TMJ Volumetric Study**	O **Endodontic Study**	O **Sinus Study**

Please circle the Region of Interest

Right  **Left**

Field of view: O 2"(XS) O 4"(S) O 6"(M) O 8"(L) O Other:_____

Desired Output: O CD and/or O Prints

Patient with: O Teeth Apart (shows occlusal views of teeth) O Teeth in Occlusion

Optional Service: O Analytical report by a pathology or radiology specialist ($65).

Please specify the reason for requesting this image: _____

_____

_____

_____

By signing below, I request the Craniofacial Imaging Center and its associates to acquire the Images and obtain authorization from the patient for these procedures.

Dr. (Print Name): _____ **Date:** _____

Signature: _____

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