CBCT REFERRAL TO BETHESDA SEDATION DENTISTRY

10401 OLD GEORGETOWN ROAD, SUITE 200
BETHESDA, MARYLAND 20814
301-530-2434

ID

Dental Practice: Bethesda Sedation Dentistry

Dental Practice Contact Person: Diane Spain

Contact person' s email: sleep@bethesdasedationdentistry.com

Dental Practice Phone: 301-530-2434

Referring Doctor: Robert Schlossberg

Patient Information & Examination

Patient Name: Last Name: First Name:

DOB:

Gender: Female

Examination: CBCT Maxilla and Mandible

Date of Examination:

Reason for examination

Implant Planning	☐ No	☐ Yes	TMJ Evaluation	☐ No	☐ Yes
Location of possible implants	☐ UR	☐ UL	Sinus Evaluation	☐ No	☐ Yes
	☐ LR	☐ LL	Airway Evaluation	☐ No	☐ Yes
Evaluation of existing implant(s)	☐ No	☐ Yes	Orthodontic Assessment	☐ No	☐ Yes
3rd Molar Assessment	☐ No	☐ Yes			
General Evaluation/Rule out pathology	☐ No	☐ Yes			

Other (please explain):

Additional clinical information pertinent to your case, that may assist our Radiologists better understand your concerns:

Urgent: ☐ No ☐ Yes

Thank you for your referral for a CBCT.

To avoid delays of the scan from being sent out to be read by the radiologist, please complete this entire form without leaving any questions blank. What size scan are you requesting? Please call the office with questions on scan size.

Circle one 5X5 8X8 10X10 11 X 17 13.5 X 17 Sinus Only TMJ Only

Referring Dr. Name (Please print) _____Phone_____

I prefer the CBCT report to be sent to me by: Circle one Email Fax

Please provide email or fax of your choice. _____

Referring Dr. Signature _____Date_____