UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

www.dental.umaryland.edu

School of Dentistry Faculty Practice

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DENTAL CONE BEAM CT REFERRAL FORM

REFERRING DOCTOR INFORMATION

NAME:
OFFICE CONTACT PERSON:
MAILING ADDRESS:
E-MAIL:
TELEPHONE #:

PATIENT INFORMATION

NAME:
ADDRESS:
PHONE:
DATE OF BIRTH:
GENDER:
SIGNIFICANT MEDICAL HISTORY:

SIGNIFICANT DENTAL HISTORY:

REASON FOR CBCT STUDY:

Pathosis evaluation: Y or N Region:
Implant evaluation: Stent provided Y or N Sites:
TMJ Study:
Other:

The radiology report will be e-mailed via secure e-mail to the e-mail address you provide above. In which format and how do you prefer to receive the CBCT volume?

Carestream 3D Viewer [ ]	**InVivo Dental [ ]**	**DICOM Data [ ]**
Send to office [ ]	**Secure e-mail [ ]**	**Send disc with patient [ ]**

Signature of referring dentist: ____ Date: _____________

TO SCHEDULE, CALL (410) 706-7961; Please email this form to DMumey@umaryland.edu; or, you may fax this form to (410) 706-0309; or, finally, you may have the patient bring this form to the School of Dentistry at the time of the appointment.