WVU Dental Care

FAX ~~(304) 293-6286~~ 304-293-7646

Cone Beam CT Imaging Referral Form

PAYMENT IS REQUIRED AT TIME OF SERVICE

Reporting of all finding, diagnosis, and treatment planning are the responsiblity of the referring doctor

PATIENT

Name:

Date of Birth:

Address:

Home Phone Number:

Mobile Phone Number:

Work Phone Number:

REFERRING DOCTOR

FAX Number:

Printed Name:

Phone Number:

Address:

Referring Doctor Signature:

Date:

PRESCRIPTION FOR CBCT IMAGING SERVICES

Specify the teeth and anatomic area(s) to be present in the image(s):

Specify the information the CBCT examination is to provide (please be specific):

Specify any medical/dental conditions that may impact the imaging process and/or patient safety (if NONE, state NONE -- this statement requires a response and must not be left unanswered)

IF A SURGICAL GUIDE IS TO BE INCLUDED IN THE SCAN, provide any special instructions here:

IF THE PATIENT DOES NOT BRING THE GUIDE WITH INSTRUCTIONS, THE SCAN WILL NOT BE MADE

SCAN TYPE ORDER (Please check the scan to be taken):

- ☐ Full maxillary arch (includes 2nd molar to 2nd molar, and the floor of the maxillary sinus)
- ☐ Full mandibular arch (includes 2nd molar to 2nd molar, and the mandibular body to the 2nd molar area)
- ☐ Full maxillary and mandibular arches in occlusion (includes 2nd molar to 2nd molar of both arches, floor of the maxillary sinus, and the mandibular body to the 2nd molar area)
- ☐ Full maxillofacial (includes the entire maxillofacial region from just below the supraorbital rims, the entire mandible, and posteriorly beyond the external auditory canals)

WVU School of Dentistry CBCT Procedure and Policy Statement

1. The referring clinician will download the PDF document of the "**Cone Beam CT Imaging Referral Form**" from the web site, type the required information in each area of the form, print and sign the form, and then FAX the completed document to the SOD Radiology area (FAX 304-293-6386).

2. If the order form indicates that a surgical guide will be used during the scan, the referring office will include instructions for its use, and be sure to instruct the patient to bring the guide to their scan appointment. If instructions indicate a guide is to be used and the patient does not bring the guide, the scan cannot be taken.

3. At the time the scan appointment is scheduled, School of Dentistry scheduling staff will inform the patient of the fee for the scan being ordered, and that they will be required to prepay before it will be taken.

4. Scan data will be copied to a CD, and the CD mailed to the referring provider within 48 business hours after the scan is taken.

5. We would like to emphasize that referring providers are responsible for having the CBCT scan data interpreted by an Oral and Maxillofacial Radiologist or Medical Radiologist for occult pathology. This interpretation extends beyond treatment planning observations and assessments made from the scan information.

6. Minimum computer specifications to be able to open the CD:

CPU/Processor Speed	2GHz Intel Duo Core or Above
RAM/Memory	4 GB
Graphics Card	3D Graphics Card with a minimum of 256 Mb of dedicated memory
Monitor	17" or larger with minimum 1024 x 768 resolution (32 bit color mode)
Operating System	•Windows 2000 SP4 •Windows XP Home/Pro SP2 •Windows Vista

7. Phone number to call if you can't open the CBCT image data on your computer: 304-293-1567