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Cone Beam CT Referral Form

Date

Appointments are made through Dental Faculty Associates (DFA) (734-764-3155). Patient should report to DFA (Room 1340, first floor, School of Dentistry) 30 minutes before appointment to register. Registration material will be sent to patient in advance if there is enough time before appointment.

Patient Information

Ordered By

Doctor Nama:		Detient Name			
Doctor Name:		Patient Name:			
Practice Name:		Phone:			
Address:		DOB:			
State/Province:		Gender:			
Zip/Postal Code:		Ethnicity:			
Phone:					
Fax:		Dental History & Medical Alerts:			
Email:					
Region to be Scanned		Reason(s) fo	Reason(s) for the Scan		
Maxilla	Mandible Both j	aws Implant(s)) Sinus	s(es)	
UR	UAnt UL	Impaction	n Traur	na	
LR	LAnt LL	TMJ	Surge	ery	
TMJ: Clo	osed mouth Open mouth	Other (ple	ease explain) 🗌 Patho	ology	
Full head (please	explain)	ROI / Impla	nt site (s)		
Scop Options					
Scan Options		Image Data	Output		
With imaging ster		Report by	Report by email DICOM files		
Specific request (please explain) Separate lip / cheek		eek	Specific request (please explain) Scan + viewer		
Comments					
	Health Hx. reviewed by:		Patient UM Reg #		
For internal use only	Referral Form reviewed by:		Date:		
	Scanning protocol:		Time:		

Please email CBCT-related questions to benavid@umich.edu or sinra@umich.edu