Indiana University School of Dentistry

Cone Beam Volume Imaging Facility Referral Form

1121 W. Michigan St., Room S125
Indianapolis, IN 46202
Phone: (317) 278-1067 Fax: (317) 278-3018

We require receiving referral prior to making patient appointment.

Patient Name: _____

Address: _____

Phone No. _____

☐ Cone Beam Volume Scan

- ☐ Maxilla: Teeth # _____ ☐ Mandible: Teeth # _____
- ☐ Sinuses ☐ Airways
- ☐ Impaction: Teeth # _____ ☐ Trauma/Pathology (specify location)

☐ Orthodontic Studies (Full Field of View unless otherwise specified)

- ☐ Beginning ☐ Progress ☐ Final

☐ Implant Placement

Implant Site(s): _____

- ☐ SIMPlant ☐ iDent
- ☐ Easy Guide – Keystone ☐ Nobel Procera (scan appliance)

☐ TMJ Evaluation

- ☐ Open ☐ Closed
- ☐ With splint ☐ Without splint

☐ Special Instructions: _____

_____

Referring Doctor:_____ Date of Referral: _____

Referring Doctor's Address: _____

_____

Phone Number: _____ Fax No. _____

Doctor's email: _____