Smileworks

CBCT / Radiography Referral Form

Practitioner Name	Patient Name
Practice Name & Address	Patient Contact Number
	Patient DOB
Practitice Contact Number	Male ☐ Female ☐
Practitice Contact Email	Patient Contact Email

TYPE OF IMAGE

- OPG ☐
- Ceph ☐
- CBCT ☐

- MANDIBLE ☐
- MAXILLA ☐
- BOTH JAWS ☐

CBCT AREAS OF INTEREST

If no teeth are selected the whole jaw will be scanned

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
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48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

CLINICAL INDICATIONS (specify resolution - low dose for ortho, standard for implantology or high for single tooth / endo)

SIGNATURE: _____

Is patient coming with a radiographic template? YES ☐ ☐ NO

Is the patient possibly pregnant? YES ☐ ☐ NO

Justification for exposure

Implants ☐	Impacted teeth ☐
Bone graft ☐	Sinus exam ☐
Ortho ☐	TMJ ☐
Endo ☐	Oral pathology ☐

2D Output

- Email ☐
- Dropbox ☐

Please complete and send as a jpeg or PDF to concierge@sexydentistry.com