

CIC

Craniofacial Imaging Center
at Case School of Dental Medicine

Patient Name _____ D.O.B.: _____

Note to Patients: Please bring this referral form with you.
Payment is due when services are rendered.
Note: The CIC is not responsible for image interpretation, reading or findings. The diagnosis and treatment planning is the responsibility of the referring doctor.

3-D Volumetric Imaging - Primary reason for the Imaging Request:

- Implants Sinus Study Microscrews (TAD) Airway Study Craniofacial Study
- Pathologic Investigation Impacted Tooth Location TMJ Volumetric Study TMJ Function Study (Video) Other: _____

Please circle the Region of Interest



- Desired Output:** CD and/or Prints **Field of view:** 4" (S) 6" (M) 8" (L)
- Patient with:** Teeth Apart (shows occlusal views of teeth) Teeth in Occlusion
- Optional Service:** Analytical report by a pathology or radiology specialist (additional fee).

Please specify the reason for requesting this image: _____

By signing below, I request the Craniofacial Imaging Center and its associates to acquire the Images and obtain authorization from the patient for these procedures.

Dr. (Print Name): _____ **Date:** _____

Signature: _____