CDI REFERRAL FORM

CDI - CRANIOFACIAL DIGITAL IMAGING
1960 Clinton Ave. South, Rochester, NY 14618
TEL: (585) 461-4459 FAX: (585) 697-2084

PATIENT INSTRUCTIONS:
1) PLEASE CALL FOR AN APPOINTMENT.
2) BRING THIS REFERRAL SLIP WITH YOU.
3) PAYMENT IS REQUIRED AT THE TIME OF SERVICE WHEN BILL PATIENT IS INDICATED.
4) INSURANCE CLAIMS WILL BE SUBMITTED FOR YOUR REIMBURSMENT.

PATIENT NAME: _____ **PATIENT PHONE:** _____

APPOINTMENT DATE: _____

SERVICE **(PLEASE CHECK √ THE APPROPRIATE BOX ON THE LEFT)**

	GENERAL & ORTHODONTIC IMAGING
☐	PANORAMIC
☐	TRACING & ANALYSIS, LATERAL
☐	TMJ CT-imaging (Bilateral) Full Series (open and closed) ☐ RADIOLOGY REPORT (optional)
	IMPLANT CT-IMAGING
☐	CT- BASED IMAGING (RADIOGRAPHIC) GUIDE (**Required only if a CT-based surgical guidance template is ordered. Patient or study models must be sent to CDI a week prior to the CT appointment.)**
☐	CONE-BEAM CT (including a hard copy report or CD) **PLEASE CIRCLE IMPLANT SITE(S)** **R** 1 2 3 4 5 | 6 7 8 | 9 10 11 | 12 13 14 15 16 **L** 32 31 30 29 28 | 27 26 25 | 24 23 22 | 21 20 19 18 17
☐	DICOM FILES OR i-VISION BURNED ON A **CD**
☐	I-DENT CT- BASED VIRTUAL SURGICAL TEMPLATE PLANNING: **PLEASE SPECIFY IMPLANT SYSTEM:** _____ **DATE OF SURGERY:** _____
☐	I-DENT CT- BASED SURGICAL TEMPLATE
	ORAL SURGERY IMAGING
☐	ORAL SURGERY CT-Imaging (bony impaction, cyst or other anomalies) **Please specify site(s):** _____
☐	DICOM FILES OR i-VISION BURNED ON A CD

REFERRING DOCTOR: _____ DATE: _____

OFFICE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (_____) _____

E-MAIL: _____

BILL ☐ **DOCTOR** ☐ **PATIENT**

DOCTOR'S SIGNATURE: _____

rev. 03-28-13