CBCT Scan Referral Form

IDEAL ENDODONTICS

Referring Doctor: _____

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Office Chart#: _____
(optional)

Contact Information

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Special Instructions: _____

_____

_____

_____

Send by: ☐ CD ☐ Printed ☐ Office email on file ☐ Other: _____

Signature and Acknowledgement

I understand that _____ involvement in connection with this referral is limited to taking the scan._____ and employees of the practice will not participate in any interpretation of the images; the preparation and issuance of the report; communicating the results of the study to the patient; or counseling the patient on appropriate follow-up as may be required in the exercise of my clinical and professional judgment. By executing this referral form, I understand, acknowledge, and accept the responsibility that, as the referring dentist it is my sole responsibility to communicate the results of the study to the patient, and to provide appropriate consultation and follow-up with the patient. I further agree to protect, defend, indemnify and hold _____ completely harmless in discharging those responsibilities to the patient. I understand that no doctor-patient relationship between my patient and _____ exists because of his or her office taking this image.

_____ _____

Referring Dentist Signature/Print Name Date

IDEAL ENDODONTICS

Notice of Non-Read Cone Beam Computerized Tomography (CBCT) Scan

Referring Doctor: _____

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____

Signature and Acknowledgement

Patient's initials required

_____ I understand that _____ involvement in connection with this referral is limited to taking the scan.

_____ _____ and employees of the practice will not participate in any interpretation of the images; the preparation and issuance of the report; communicating the results of the study; or counseling the patient on appropriate follow-up as may be required in the exercise of clinical and professional judgment.

_____ By signing this form, I understand, acknowledge and accept that my referring dentist has the sole responsibility to communicate the results of the study to me and to provide appropriate consultation and follow-up.

_____ I understand that _____ will be responsible for reviewing, evaluating, and diagnosing the imaging data.

_____ Furthermore, I understand that no doctor-patient relationship between _____ and me is formed because of his or her office taking this image.

_____ _____

Patient or Patient's Representative Signature Date

_____ _____

Witness' Signature Date