Limited Referral for Dental CT Image

Patient________________________________DOB_______

Referring Provider:_________________________________

503-385-8821

info@drakeperio.com

This is a **limited-purpose referral** for a dental computerized tomographic image of areas requested by the referring provider. Patients and the referring provider should discuss the need, benefits and risks of this image compared to alternatives, radiation comparisons and issues the referring provider considers relevant. This oral and maxillofacial surgery office is **only taking the Image**. Nothing provided by this office shall be interpreted as a diagnosis, treatment recommendation or treatment (unless the patient is specifically **referred for that purpose in writing**, and accepted by this office).

REGION TO BE SCANNED:

__ Maxilla __ Mandible __ Both

__ __ Right Side __ Left Side

TEETH: The entire jaw will be scanned unless the referring provider designates the tooth or teeth below, or

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	

describes a tooth not on this chart:_________________________________

POSITION OF TEETH DURING SCAN: ___ Together ___ Separated __ With Appliance

EVALUATION PURPOSE:

The referring provider requests this image to help plan or assess the following care or treatment:

____

INTERPRETATION: If a patient is referred to our practice by another provider for a CT image, the policy of this office is to order a radiology report with an interpretation at the patient's expense. This office will not interpret the image or advise the patient. **If the referring provider only requests an image without a radiology interpretation the provider must check the box below, and assume full responsibility for obtaining an interpretation by a qualified provider.** ☐

Referral Date:______________

Signature of Referring Provider (required):________________________________

Referring Provider's contact info: Phone:______________ email:____________________

Mailing Address:____________________________

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PATIENT CONSENT FOR CT CONE BEAM IMAGE:

CT Cone Beam Imaging: These images may help your health care provider diagnose, consider treatment options, identify possible complications or make treatment or other decisions. If you have any questions you should discuss them with your referring provider after the images are received and reviewed. This office is only taking the image and will not provide or discuss a diagnosis, treatment plan, possible complications or treatment options.

Radiation Exposure: CT cone beam images expose patients to radiation as do other forms of imaging. Our office strives to use the "as low as reasonably attainable" approach to radiation, but this is affected by what your referring provider requests. Radiation exposure is cumulative over the patient's lifetime. Exposure from all imaging, along with natural exposure to sunlight and other radiation sources may be linked to a slightly higher risk of cancer you should discuss with your referring provider or others who have knowledge of other possible radiation exposures.

Pregnancy: Women who are pregnant should not undergo CT cone beam imaging unless your referring provider and OBGYN conclude the need for the image outweighs the risks. Please advise our staff if you are pregnant, think you might be or are trying to become pregnant, and initial this box ☐

Your Images: Images will be downloaded to a media you must take to your referring provider. **Once you take possession of this information it shall become your responsibility to maintain and protect your private health information and prohibit anyone you don't want viewing this information from gaining access to it.**

Interpretation of Images: This oral and maxillofacial surgery office will only view the images requested by your treating provider to ensure the areas requested were imaged. We will not interpret these images or provide any other advice. You should get this information from your referring provider after he or she has the opportunity to discuss all relevant information with you. Unless your referring provider requests otherwise we will send the image to an independent radiologist and request a report to be forwarded to your referring provider. You will be responsible for paying the radiology fee. If your referring provider requests imaging without a radiology report your referring provider will be responsible for obtaining a report or interpreting the image.

Patient or Legal Guardian's Consent: Do not sign this document unless you read the entire document, had questions answered by the oral and maxillofacial surgeon and voluntarily agree to all statements in this document.

Being 18 years old or older (or being the legal guardian or parent of a patient under 18), I certify that I have discussed the benefits and risks of alternative images with my referring provider, read all the above statements, understand them, have had questions answered to my satisfaction and agree to proceed with CT cone beam imaging as requested by my referring provider.

Signature of patient over 18 (or legal guardian):______________________________: Date signed:_____________

Print Name of Patient:__________________________

Print Name of Person Signing:__________________________

Witness Name/Signature:___________________________