Long Orthodontic Associates, LLC
www.loasmiles.com

REFERRAL FORM FOR CONE BEAM (I-CAT) SCAN

DATE: _____

PATIENT NAME/DOB: _____

PATIENT PHONE NUMBER: _____

REFERRED BY: _____

REFERRER'S E-MAIL: _____

REASON FOR REFERRAL:

- ☐ pathology
- ☐ implant (tooth/teeth# _____)
  format: ☐ Nobel ☐ Simplant ☐ Other _____
- ☐ TMJ
- ☐ oral surgery/impaction (tooth/teeth# _____)
- ☐ sinus
- ☐ airway
- ☐ other _____

CT SCAN RANGE ☐ MAXILLA ☐ MANDIBLE ☐ FULL HEAD/NECK

FORMAT DESIRED: ☐ SINGLE DICOM ☐ MULTI DICOM ☐ HARD COPY

COMMENTS: _____
_____
_____

1801 FRUITVILLE PIKE, LANCASTER, PA 17601 · ph (717)569-7001 · fx (717)569-3476