CRESCENT

ORAL SURGERY

ORAL AND MAXILLOFACIAL SURGEONS
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Dr. Kris Lee ext 8333
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Patient Name: _____ Referral Date: _____

Age: _____ Tel: (h) _____ (c) _____

Referred by: Dr. _____ Tel: _____

Address: _____

Appointment Date: _____ Time: _____

Reason for referral:

Right 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 Left
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Right E D C B A | A B C D E Left
E D C B A | A B C D E

❑ Implants ❑ Trauma ❑ Extractions ❑ TMJ

❑ Pathology ❑ Orthognathic Surgery ❑ CBCT/Radiology (see over)

❑ Discuss anesthetic options ❑ X Rays sent with patient

❑ X Rays mailed ❑ Please take X Rays

Comments/Details: _____

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Radiology Requisition Form

Areas of Interest (please circle)

Q1	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	Q2
Q4	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	Q3

❑ **Implant Treatment Planning**

❑ Stent Provided Yes / No ❑ Include Zygoma

Slice size ❑ 2 mm ❑ Crestal Width ____ mm

❑ ____ mm ❑ Mid Alveolar Width

❑ **Orthodontic Treatment Planning**

❑ PAN ❑ CEPH ❑ Asymmetry Evaluation ❑ Facial CBCT

❑ **TMJ Evaluation**

Area/Reason for concern: _____

❑ Stent Provided Yes / No (please circle)

❑ Closed only ❑ Open and closed

❑ **Pathology Investigation**

Area of concern: _____

_____

❑ **Other:** _____

_____

_____

IMAGE FORMAT:

❑ Print out ❑ Disc only

❑ Email: _____ @ _____ . _____