



# Center for Specialized Dentistry

Excellence Experience Compassion Commitment

Dr. John V. Louis, DMD, LLC

## CT & Digital Scan Referral Form

### Referring Doctor Information

Referring Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: Street: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Medical Alerts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Prescription for CT & Digital Scan

Please specify the type of scan format you require:

\_\_\_\_\_ CT Data with viewing software      \_\_\_\_\_ STL Digital File

\_\_\_\_\_ Raw CT Data to import into your preferred software      \_\_\_\_\_ Digital Photo

The patient is referred for a CT & Digital scan analysis. The scan should occur so that the axial plane is parallel to the natural teeth or a scanning guide template.

The patient \_\_\_\_\_ will \_\_\_\_\_ will not be wearing a negative image scanning guide template that is provided by the referring doctor during the scanning process.

### Diagnosis

The zone of interest is:

\_\_\_\_\_ Full Head and Neck/Standard Size 3-Dimensional (13 cm)

\_\_\_\_\_ Both Arches/Panoramic Size 3-Dimensional (8 cm)

\_\_\_\_\_ Maxilla 3-Dimensional (6 cm)

\_\_\_\_\_ Mandible 3-Dimensional (6 cm)

\_\_\_\_\_ Panoramic Radiograph 2-Dimensional (8 cm)