ADVANCED ORAL SURGERY & DENTAL IMPLANT STUDIO

RX: DENTAL CONE BEAM CT SCAN

Patient: _____

Date of Birth: _____

Referring Provider: _____

REGION(S) OF INTEREST OF CBCT SCAN

☐ MAXILLA ☐ MANDIBLE ☐ BOTH ☐ TMJ ☐ RIGHT ☐ LEFT

☐ TOOTH (as indicated) ☐ TEETH (as indicated)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

***If no site is indicated, the entire jaw will be scanned.**

SCAN PATIENT

☐ WITH TEETH TOGETHER ☐ WITH TEETH SEPARATED ☐ WHILE WEARING APPLIANCE

REASON FOR CBCT SCAN — TO EVALUATE

☐ DENTOALVEOLAR STRUCTURES
☐ DENTAL IMPLANTS OR GRAFTING
☐ MAXILLOFACIAL PATHOLOGY
☐ TMJ (BONE ONLY)
☐ OTHER (PLEASE DESCRIBE) _____

_____

INTERPRETATION OF CBCT SCAN (Selection must be initialed by referring provider!)

Dental CBCT scans will be sent out for interpretation, with an additional cost for that service, unless specifically noted and initialed below!

_____ ☐ **Do NOT send for interpretation; referring provider will interpret scan.**
Initial

ADDITIONAL/OTHER STUDIES REQUESTED (additional cost incurred)

☐ STL MODEL SCAN (model must be supplied)
☐ EXTRAORAL BITE-WING VIEW
☐ DIGITAL PANORAMIC VIEW
☐ 3D FACIAL PHOTO
☐ EXTRAORAL PA/REGIONAL VIEW (as indicated)
☐ SCAN APPLIANCE (Dual Scan Protocol)

Referral Date: _____ Referred By: _____
(Signature Required)

Referral Phone: _____ Referral Email: _____

Prescription must be signed by provider! Please keep a copy for your records.

ADVANCED ORAL SURGERY (AOS) INFORMED CONSENT FOR CBCT SCAN

Advantages of a CBCT scan: Diagnosis and treatment planning, which will be determined by your referring provider, may be enhanced by obtaining 3D imaging. Benefits of CBCT scans include but are not limited to: A) Providing images and information for diagnosis and evaluation that may direct treatment and/or may assist in avoiding unnecessary treatment; B) Enhanced visualization of tooth position and proximity to vital structures such as nerves or the sinuses; C) Improved accuracy when planning dental implants, evaluating for bone grafting, and implant guides; D) Potential for diagnosing vertical root fractures that may not be visible on some traditional dental X-rays; E) Improved definition of jaw pathology and trauma.

Radiation Exposure: CBCT scans expose you to radiation, which may be cumulative over your lifetime and may be linked with a slightly higher risk of developing cancer. The exposure of a CBCT scan is less than the amount of exposure of several days in the sun. ADS applies the ALARA principal (As Low As Reasonably Attainable) in all scans taken by using reduced regions of interest and application of pulsed exposure protocols of the iCat.

Pregnancy: Pregnant women should **NOT** undergo a CBCT scan due to the potential danger to the fetus. Please advise AOS staff if you are pregnant or actively trying to become pregnant.

Images: Your scan will be stored at AOS in a HIPAA-compliant manner. You will receive your scan with a viewing program on a CD to take to your referring provider. The CD is not encrypted and your scan could be viewed by anyone if you lose or misplace it. It is your responsibility to protect and secure the CD and the associated personal information it holds. Additional copies of your scan can be provided at an additional cost.

Interpretation and Reading: You will need to rely on your referring provider or an Oral and Maxillofacial Radiologist (OMFR) for interpretation of your scan. AOS will take the scan that has been requested, but will only evaluate the scan for 'quality' and to ensure the 'region of interest requested' was imaged. AOS staff and technicians will not interpret, diagnose, or provide treatment recommendations for you. **NOTE: Unless indicated in writing, AOS will send your scan for a formal reading by an Oral and Maxillofacial Radiologist at an additional cost, which must be paid in advance of sending the scan.** Your referring provider may determine the need to send your scan for a formal reading and you may also request your referring provider send your scan for a formal reading.

Consent for a Dental CBCT Scan: I, being 18 years or older, certify that I have read the above. I understand the prescribed procedure to be done and its benefits, risks, and alternatives. I acknowledge that I have had the opportunity to discuss the matter and options with my referring provider and to have my questions answered. I acknowledge that I will only rely on my referring provider or an OMFR (Radiologist) and **NOT** AOS for any interpretation, diagnosis, or treatment planning opinions. I understand and accept the risks of the CBCT scanning procedure as described. By signing below, I give my consent to have AOS perform a CBCT scan as prescribed by my referring provider for myself or as my responsibility as guardian.

_____
Signature of Patient or Legal Guardian

_____
Printed Name

_____
Date

_____
Witness