DENTAL / AIRWAY CT SCAN REFERRAL FORM

SLEEP APNEA
—SOLUTIONS—

Date: ____________ Patient Name: __________________________ D.O.B.: ____________

Patient Phone: ____________________ ☐ Please Call Patient ☐ Patient will call for appointment

Ref. Doctor Name: ________________________ Practice Name: ______________________

Doctor Address: ____

Doctor Phone: ____________________ Email Address: ____________________________

REGION OF INTEREST (select teeth or area to be treated)

Right Maxillary

R

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

Right Mandibular

Left Maxillary

L

Left Mandibular

Special Instructions: ____

____

CASE TYPE (select one)

☐ IMPLANT

☐ PATHOLOGY

☐ IMPACTION

☐ SINUS/AIRWAYS

☐ TMJ STUDY

☐ ORTHO

☐ PATHOLOGY

☐ OTHER ____________________

CT Scan Delivery

☐ RETURN TO OFFICE W/ CD

☐ SEND W/ PATIENT

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