Health Sciences Center
Department of Diagnostic Sciences
PO Box 9465 Morgantown, WV 26506
Phone: 304-293-4659
Email: sodreferrals@hsc.wvu.edu

Please email the completed form to sodreferrals@hsc.wvu.edu.
Staff will contact the patient for scheduling an appointment.
Payment is required when services are rendered.

CBCT Imaging Service Prescription Form

Referring Clinician

Name: ______________________________ Signature: ______________________

Office Phone Number: ______________________ Date: ______________________

Patient Information

Name: ____ Date of Birth: ______________

Address: ____
Street City State Zip Code

Home Phone Number: ______________________ Cell or Work: ______________________

Referral Reason: ____

Additional Information/Clinical Diagnosis: ____

Region and Field of View	**Scan options**
O Maxilla O Mandible O Both jaws without cranium O Both jaws with cranium O Limited view less than 1 jaw specify location____________ O TMJ series (open and close mouth scans)	O Scan with Stent (patient wearing stent) O Scan Stent separately O Separate jaws O Separate lip/cheek Comments on scan option_______________
Reason for scan O Implants O Impaction O TMJ O Pathology O Other- please explain Comments on reason for scan_______________	**Image Data Output** O DICOM files O Scan with viewer included