CADE Imaging Center
Saint Louis University

Patient Name:_____

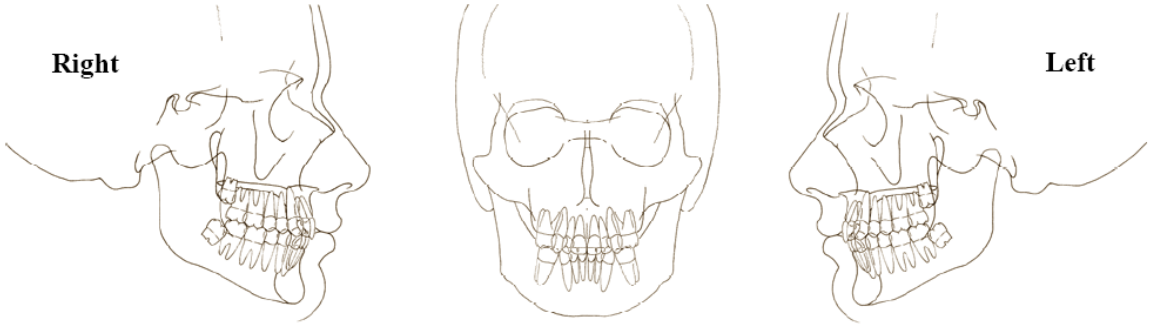
Sex: _____ **Date of Birth:** _____

Note to Patients: Please bring this referral form with you. Payment is due when services are rendered.
Note: CADE Imaging Center is not responsible for image interpretation, reading or findings. The diagnosis and treatment planning is the responsibility of the referring doctor.

3-D Volumetric Imaging: Primary Reason for the Imaging Request:

☐ Impacted Tooth	☐ TMJ Exam	☐ Implants
☐ Miniscrew (TAD)	☐ Pathology	☐ Sinus Study
☐ Airway Exam	☐ Craniofacial Exam	☐ Other:_____

Please circle the Region of Interest



Field of View

☐ Maxilla and Mandible ☐ Maxilla only ☐ Mandible only ☐ TMJ only

Please specify the reason for requesting this image:

_____
_____
_____

By signing below, I request CADE Imaging Center to acquire the images and obtain authorization from the patient for these procedures.

Dr. (Print Name):_____ Phone Number:_____
Mailing Address:_____
Signature: _____ Date: _____

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