Imaging Services Referral Slip

Please complete this form in its entirety.

If the referral slip is incomplete, the imaging services will not be provided.

Referring Doctor Name _____

Address _____

Phone Number _____

Patient Name _____

Imaging Service Anatomical Location _____

Diagnosis _____

_____

_____

Dr. _____ agrees to have the images read by a Medical or Oral

(Print Referring Doctor Name)

and Maxillofacial Radiologist, to take full responsibility for the radiological interpretation of the images, and hold **Dr. Gronbach and East Bay Oral Surgery** harmless in the event the images are not read by a medical or Oral and Maxillofacial Radiologist or the appropriate follow-up is not given to the patient.

Imaging services means Cone Beam Computed Tomography imaging services which are limited to the head and neck region and limited to CT imaging without IV contrast.

In order for these services to be provided, the referring healthcare professional agrees to the provisions of the imaging services referral slip. It is mandatory that the referring healthcare professional sign and date below.

Signature Date