



**The Dental Center at Western University
Oral Maxillofacial Radiology Referral Form
795 E. Second Street. 3rd floor, Suite 8 Pomona, CA 91766
Tel: (909) 706-3910 FAX: (909) 469-8650**

****Referring Doctor: Please fill out completely referral form and fax a copy of this request form prior to patient appointment.
Patient: Please call Monday – Friday 9:00 am - 4:30 pm to schedule an appointment ***.*

Today's Date: _____

PATIENT INFORMATION:

Name: _____ D.O.B.: _____
Telephone: _____

REFERRING DOCTOR:

Name: _____
Address: _____
Telephone: _____
Email: _____
Signature: _____

PROCEDURES REQUESTED (check all that apply)

Lateral Ceph Panoramic Full Mouth X-rays

CONE BEAM CT (check all that apply):

Small volume- one to a few teeth
 Medium volume -Mandibular
 Medium volume - Maxillary
 Large volume - both jaws

SPECIFY EXAM (required information)

Implant (specify site): _____
Orthodontic Assessment (specify site): _____
Endodontic Assessment (specify site): _____
Sinus Assessment (specify site): _____
TMJ: (specify site) : _____

Special Instructions: _____

****Payment is due at the time services are rendered**