Updated 12/2021

SIU Dental Associates

RADIOLOGY
PATIENT REFERRAL FORM

Patient Information

Name: _____

Birth date: _____ Gender: ☐ M ☐ F

Address: _____

_____

Phone: _____

Dental Ins: _____

Medical Ins: _____

ID #: _____

Preferred Doctor

☐ First available

☐ Dr. Debra Dixon

Referred by:

Name: _____

Facility: _____

Phone: _____

Requested Radiographs (please select all that apply)**:**

__ Panoramic
__ Lateral Ceph
__ Posterior-Anterior Ceph
__ CBCT
__ CBCT with Guide
__ CBCT of Guide Only
__ Occlusal
__ Other: _____

CBCT Only (please select regions that apply)**:**

__ Maxilla
__ Mandible
__ Maxilla and Mandible
__ Specific Teeth: _____
__ Upper Airway Space
__ Entire Skull
__ TMJ

Additional Information about Area of Interest and/or Preliminary Diagnosis:

Relevant Clinical History:

Signature of Referring Provider: _____ Date: _____

Please return patient for general care to referring provider. ☐ Yes ☐ No

To transfer patient records and radiographs electronically, please visit the following URL: https://sdm.siue.edu/xraydropboxfp/uploadxrays.php. Please include your office name/phone number, patient name/date of birth, and date of radiographs.

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