RIVERVALLEY
ENDODONTICS
Harish K. Malyala, DDS

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Cone Beam Computed Tomography (CBCT) Referral Form

Ordered By (Referring Provider)

Doctor Name: ______________________

Practice Name: ______________________

Address: ______________________

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Phone: ______________________

Fax: ______________________

Email: ______________________

Patient Information

Patient Name: ______________________

Phone: ______________________

Date of Birth: ______________________

Address: ______________________

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Email: ______________________

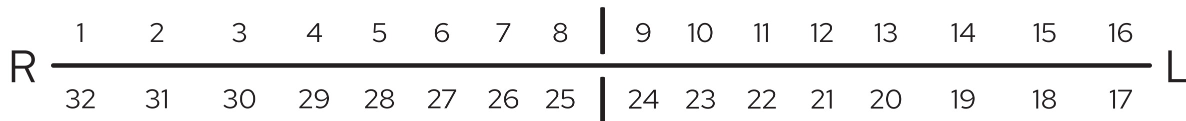
Dental History & Medical Alerts: ______________________

Region to be Scanned:

☐ Upper Right ☐ Upper Anterior ☐ Upper Left

☐ Lower Right ☐ Lower Anterior ☐ Lower Left

☐ Maxilla ☐ Mandible ☐ Both Jaws



Reason(s) for the Scan:

☐ Implant ☐ Impaction ☐ Sinus(es) ☐ Pathology ☐ Trauma ☐ Surgery

☐ Other, please explain: ______________________

The referring doctor takes full responsibility for the radiological interpretation of the images and holds Harish K. Malyala, DDS harmless in the event images are not read by a radiologist or the appropriate follow-up is not given to the patient.

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 dentist sign and date below.

______________________ ______________________

Referring Doctor Signature Date

Patients may also request that all images be read by a radiologist.

Please check one:

☐ I request that Dr. Malyala send this CBCT scan to an oral radiologist for a $125.00 fee payable by me.

☐ I request that Dr. Malyala **NOT** send this CBCT scan to an oral radiologist for further review.

______________________ ______________________

Patient Signature Date

Please email referral to info@rivervalleyendodontics.com or fax referral to 859-261-2749.