Clarkson Imaging
Head & Neck 3-D Imaging

Patient Name _____

Important Patient Information: (Appointment necessary) Fees for service are due at time of the appointment

Scan
__ iTero Intraoral Scan
__ Trios Intraoral Scan
Send to Lab Name: _____
Purpose of Scan/Area of Interest:
_____
_____

Cone Beam Volume Scan (iCAT)
__ Full height (nasal bone to inferior mandible, 11mm height)
__ Maxilla
__ Mandible
__ Maxilla & Mandible
__ TMJs
__ Sinus
__ Specify Site _____
_____
Purpose of Scan/Area of Interest:
_____
_____
__ I am sending a stent with patient
__ Radiographic interpretation by radiologist (please note, unless marked, Clarkson Imaging will not interpret the scan results. The ordering doctor is responsible for the information obtained by the scan.)

Please deliver the (iCAT) by:
__ CD: Dicom File
__ CD: Dicom File with viewing software
__ CD: Study File
__ Dropbox Secure File Transfer

ICD-10 Code:
ICD-10 Indicator:

Doctor's Signature:
_____

Doctor's printed name:
_____

Doctor's phone number:
_____ _____

Date: _____ / _____ / _____

Location Map

636.394.7570
info@clarksonimaging.com
2997 Clarkson Road, Suite 220 • Chesterfield, MO 63017
www.clarksonimaging.com