ENDODONTIC SPECIALTY GROUP

Practice Limited to Endodontics

CBCT/Panoramic Scan Request

Patient Name: _____

Appointment: Date: _____ Time: _____ am pm

Please list tooth/teeth or area for endodontic evaluation and/or treatment: _____

Comments: _____

CBCT ONLY

❑ Please perform a Small Field CBCT scan of tooth/teeth or area (50 mm x 37 mm). Available on CD.

_____

PANORAMIC ONLY

❑ Please perform digital panoramic radiograph:

Send by: ❑ CD ❑ Printed ❑ Office email on file ❑ Other email: _____

_____

Signature and Acknowledgement

Edward R. Kirsh, DDS and Jared E. Lichstrahl, DMD or their Associates/Agents individually, and on behalf of the Endodontic Specialty Group, will have the requested images read by myself, the referring dentist or a medical or dental radiologist whose report will be forwarded directly to me, the referring doctor. I understand that Drs. Kirsh, Lichstrahl or Associates/Agent's involvement in connection with this referral is limited to exposing the x-ray. Drs. Kirsh, Lichstrahl, Associates and employees of the group will not participate in any interpretation of the images; the preparation and issuance of the report; communicating the results of the study to the patient; or counseling the patient on appropriate follow-up as may be required in the exercise of my clinical and professional judgment. By executing this referral form, I understand, acknowledge and accept the responsibility that as the referring doctor it is my sole responsibility to communicate the results of the study to the patient and to provide appropriate consultation and follow-up with the patient, and I further agree to protect, defend, indemnify and hold Drs. Kirsh, Lichstrahl and Associates/Agents and the Endo Group, PLLC completely harmless in discharging those responsibilities to the patient. I understand that no doctor-patient relationship between my patient and the Doctors of the Endodontic Specialty Group is formed as a result of his or her office taking this image.

Referring Doctor Signature / Print Name Date

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Record of Discussion and Informed Consent for <u>Outside Referral</u> CBCT Request

Name (Last/First):_____
Address:_____
City:_____ **State:**_____ **Zip:**_____
Birthdate:_____ **SSN/Patient ID #:**_____
Telephone Number: _____ **Cell:**_____

1. **What is a CBCT Scan:** A CBCT scan, also called cone beam computerized tomography, is a three-dimensional x-ray technique that is like medical CT scans. CBCT scans are primarily used to visualize bony structures and teeth, not soft tissues such as your tongue and gums.

2. **Advantages of a CBCT scan**: CBCT examinations provide a 3D image, which may be used for the diagnosis and treatment planning, for endodontic treatment, dental implants and surgery. By using a CBCT, we have an enhanced ability to understand conditions that can be missed on a conventional x-ray.

3. **Radiation risks:** CBCT scans, like conventional x-rays, expose you to radiation. There are certain inherent and potential risks from x-rays. The dose is approximately the same as the following U.S. background radiation dose equivalents: 1 day for upper teeth, 3 days for lower front teeth and 5 days for lower back teeth. An alternative to a CBCT scan is conventional dental x-rays, however, they have the limitations previously noted.

4. **Women:** CBCT scans are generally NOT recommended for pregnant women because of possible danger to the fetus.
(Initial as appropriate) _____ I am not pregnant _____ I am pregnant _____ I am unsure whether I am pregnant

5. **Diagnosis of non-dental conditions**: While parts of your anatomy beyond your mouth and jaw may be seen on the scan, we are neither physicians nor radiologists and will not make assessments concerning your anatomy beyond your mouth or jaw. If the report raises a question as to something unusual outside the specific area of your mouth or jaw, we may refer you to a physician or radiologist for an evaluation. In such an event, our office can place the image on a CD. You should also understand that CBCT scans cannot be relied upon to show soft tissue lesions, unless they have caused changes in your hard tissues (teeth or bone). Also, CBCT images may contain artifacts that can make interpretation difficult.

I certify that I have read this consent form and that I understand the procedure to be performed, and its benefits, risks and alternatives. I acknowledge that I have had a full opportunity to discuss this procedure with my referring/treating dentist.

Thus, I give my informed consent to the doctors of the Endodontic Specialty Group and their employees to perform the CBCT scan. I also acknowledge that Drs. Kirsh, Lichstrahl and their Associate's sole responsibility is to perform the study; that I will not be examined by the doctors or their employees, nor will they be reviewing the radiographic images that will be taken during the examination for diagnosis or treatment purposes. Instead, the scan will be reviewed by Drs. Kirsh, Lichstrahl or their Associates only to make certain that it is a satisfactory x-ray image for the referring doctor to use for diagnostic or treatment purposes prior to sending it to that doctor. The study will be interpreted by a qualified medical or dental radiologist; that the report of the study will be forwarded directly to my referring/treating dentist and that Drs. Kirsh, Lichstrahl or their Associates, nor any of their employees will be involved in communicating the results of the report to me; interpreting the study or in providing counseling concerning the results of the study.

Therefore, I hereby release, acquit and forever discharge Drs. Kirsh, Lichstrahl and the Endodontic Specialty Group, its employees, associates, agents and representatives, from any and all claims, causes of action, damages, or judgments, whether in contract or in tort, for any injuries including personal that may be incurred arising out of or in any way connected to missed or lack of diagnosis or treatment, since I understand that Drs. Kirsh, Lichstrahl and/or Associates are not my treating doctors. No doctor-patient relationship is formed as a result of our office taking this image.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT AND AGREE WITH WHAT IT SAYS

Patient Signature: **X** _____ _____
(If under 18 years old, parent or legal guardian; relationship to patient): _____ Date

Print Name: _____ Assistant Signature: _____