



Imaging Services Referral Slip

Please complete this form in its entirety. If the referral slip is incomplete, the imaging services will not be provided.

Dr. _____ is referring patient _____
(Referring doctor) (Full Name)

for imaging service on _____
(Anatomical Location)

for _____
(Diagnosis)

Dr. _____ agrees to have the images read by a medical or dental
(Referring doctor)

radiologist, take full responsibility for the radiological interpretation of the images and hold ***Heart of the Brazos Oral & Facial Surgery*** harmless in the event the images are not read by a medical or dental radiologist or the appropriate follow-up is not given to the patient.

Imaging facility services means CT imaging services which are limited to the head and neck region and limited to CT imaging with no contrast.

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 healthcare professional sign and date below.

Signature

Date

Print Name