SCHOOL OF DENTAL MEDICINE
CASE WESTERN RESERVE UNIVERSITY

Oral and Maxillofacial Radiology Clinic
CWRU School of Dental Medicine
9601 Chester Ave
Cleveland, OH 44106
Ph: 216-368-6802

Oral and Maxillofacial Radiology Prescription Form

Referring Doctor's Information	Patient's Information
Practice Name: Street Address: City: State: Zip: Phone: Fax: Email:	Name: Date of Birth: Age: Sex: Study Date: Study: Previous Study:

Pertinent Medical History:

Region of Interest / Clinical Indication:

Clinical Information (Signs, symptoms):

Clinical diagnosis:

Any specific questions to be answered in this study:

☐ I have obtained authorization from the patient to release medical and dental information to Dr. Ali Syed for the purpose of consultation.

Doctor's Name: Specialization:

Signature: Date:

Please fax the form to: 216-368-3627

http://dental.case.edu/ommds/clinic/