



KING SAUD UNIVERSITY
COLLEGE OF DENTISTRY
ORAL & MAXILLOFACIAL RADIOLOGY CLINIC

Request for Radiographic Examination

MEDICAL ALERT:

File Number:.....
Patient Name:.....
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Age:.....
Date of Request:.....
Cubicle Number:.....
Clinical Section:.....

Student Name..... Number.....

Resident/Intern Name..... Number.....

Faculty Name, Number and signature.....

Reason for requesting radiographs, relevant patient history and clinical findings:

Requested Radiographs	
Periapical of	
Premolar Bitewings:	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Vertical
Molar Bitewings:	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Vertical
CMS:	<input type="checkbox"/> 20 Films <input type="checkbox"/> 12 Films <input type="checkbox"/> 8 Films <input type="checkbox"/> Vertical Bitewings
<input type="checkbox"/> Panoramic	
<input type="checkbox"/> Lateral Cephalometric	<input type="checkbox"/> Hand & Wrist <input type="checkbox"/> PA Cephalometric 45° Lateral Cephalometric: <input type="checkbox"/> Rt <input type="checkbox"/> Lt
<input type="checkbox"/> Occlusal of:.....	<input type="checkbox"/> Lateral Skull <input type="checkbox"/> PA Skull
Lateral Oblique:	<input type="checkbox"/> Rt Body <input type="checkbox"/> Rt Ramus <input type="checkbox"/> Lt Body <input type="checkbox"/> Lt Ramus
<input type="checkbox"/> Water's (OM)	<input type="checkbox"/> SMV (Basal View) <input type="checkbox"/> SMV (Zygomatic Arch) <input type="checkbox"/> PA Mandible
<input type="checkbox"/> Reverse Towne	

Special Investigations	
<input type="checkbox"/> TMJ Tomography	Parotid Sialography: <input type="checkbox"/> Right <input type="checkbox"/> Left
	Submandibular Sialography: <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Implant Tomography:	Area of:.....
<input type="checkbox"/> Others:.....	

Date of Examination:..... Operator:.....