

**UNIVERSITY OF LOUISVILLE  
SCHOOL OF DENTISTRY**

***DIVISION OF RADIOLOGY AND IMAGING SCIENCES***

**AUTHORIZATION AND RELEASE FOR PERFORMANCE OF DIAGNOSTIC  
RADIOGRAPHIC PROCEDURES**

You have the right to be informed about your condition and the recommended treatment plan to be used so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may give or withhold your consent.

**PROCEDURE** - I hereby freely and willingly consent for Dr. FARMAN / SCARFE or any trained radiographer or dentist who is working with them to perform the following radiographic procedure:

Cone Beam Computed Tomography

A number of X-rays will be taken, depending on the procedure necessary to provide your referring clinician with additional information. You will not experience any discomfort during the examinations. Your X-rays will be labeled and then presented to the Oral and Maxillofacial Radiologist for interpretation. Each radiograph has a full written report provided to the referring clinician and requires time to reconstruct. Therefore no comment will usually be made by the radiographer or radiologist at the time of your procedure.

**RISKS** - Dr. FARMAN / SCARFE has explained to me that there are certain inherent and potential risks in the use of radiation, and that in this specific instance such risks have been minimized by the use of a highly collimated X-ray beam, the latest technology in X-ray detectors and the use of lead aprons. The potential long term risks to you or any unborn child from these X-ray doses are uncertain, but these doses have never been associated with any definite adverse effects. The radiation you get from each X-ray is the same amount of radiation you get from the atmosphere in approximately 2 days. Thus the risk to you is minuscule, and within the National Institute of Health Radiation Safety Guidelines for patients.

**GUARANTEE** - No guarantee or assurance has been given to me that the proposed radiographic examination will be completely diagnostic to my complete satisfaction. We don't guarantee that we will be able to provide the clinician with all the radiographic information possible from this radiograph. Due to individual patient differences, there exists a risk of not being able to provide an ideal X-ray for each procedure. In order to achieve adequate information from good quality radiographs, a number of radiographs may have to be repeated. There is no additional cost to you for the extra X-ray.

**PREGNANT WOMEN** - If you are a woman, you will be questioned regarding pregnancy. If you are pregnant, or you are unsure if you are pregnant, you will be given the option not to have X-rays taken due to the unknown risk of the embryo or fetus from the X-rays.

**REFUSAL OF PROCEDURE** - Your decision to undergo this radiographic examination is voluntary. You may refuse to participate or discontinue participation at any time. Your decision will not affect your future care at the School of Dentistry at the University of Louisville. However you should be aware that this procedure has been requested to provide the referring clinician additional information on your condition which is not available clinically. Refusal for the procedure will result in lack of information which could result in a less than optimum treatment for your condition.

**PAYMENT** - The Division of Radiology and Imaging Sciences Private Practice service operates on a "fee-for-service" basis and that fees are normally payable in advance. I recognize that any quoted fee is subject to change based on the circumstances of my dental problems. I authorize the School of Dentistry to release any information and records concerning my treatment as may be necessary to process insurance claims or payment for the care and treatment provided.

**ADDITIONAL QUESTIONS** - All questions have been answered in a language that you can understand. If you have any further questions now, feel free to ask us. If you have any additional questions later, they will be handled in the identical manner. Dr. FARMAN is available at (502) 852-1241, to answer all questions you may have. You may also call DR. SCARFE at (502) 852-1226.

You will be given a copy of this form to keep.

PLEASE ASK IF YOU HAVE QUESTIONS CONCERNING THIS CONSENT FORM.

\_\_\_\_\_  
Patient's (or legal guardian's) signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness' signature

\_\_\_\_\_  
Date

**To provide us with information to assist in the radiologic assessment of your condition please provide answers to the following questions:**

REFERRING DOCTOR: \_\_\_\_\_

REASON FOR X-RAY: \_\_\_\_\_

DATE of BIRTH: \_\_\_\_\_ / \_\_\_\_\_ /19

Any history of trauma to your head, neck or shoulders? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous Orthodontic treatment \_\_\_\_\_