CBCT IMAGING AND REPORTING SERVICE

UCSF Dental Center – Oral & Maxillofacial Radiology
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CBCT interpretation Referral form

Referring Dentist Information

Name: _____

Email: _____

Telephone No.: _____ Fax: _____

Mailing Address: _____ _____ _____ _____
Street City State Zip Code

Patient Information

Name: _____ Date of Birth:_____ Sex: _____

Home Address: _____ _____ _____ _____
Street City State Zip Code

Telephone No.: _____

CBCT information

Date of CBCT: _____

Reason for consult: _____

Specific region of interest: _____

Relevant clinical history and findings: _____

CBCT interpretation report Fees: $98.00

For instructions on sending CBCT images for interpretation contact dental.radiology@ucsf.edu

***PLEASE EMAIL COMPLETED FORM TO:** dental.radiology@ucsf.edu **