Imaging Request Form (2D)

Oral and Maxillofacial Radiology
UConn School of Dental Medicine
263 Farmington Avenue, MC 2110, Farmington, CT 06030-2110
Phone: 860-679-2718, Email: omfrclinic@uchc.edu

THIS SECTION MUST BE COMPLETED

DATE OF ORDER: ____

REFERRING DR: ____

ADDRESS: ____

TELEPHONE: ____

FAX: ____

EMAIL: ____

PATIENT'S NAME: ____

Last First

DATE OF BIRTH: ____

GENDER: ____

ADDRESS: ____

____

TELEPHONE: ____

RELEVANT CLINICAL HISTORY

IMAGING REQUESTED: [CHECK APPROPRIATE]

____PANORAMIC

____CEPHALOMETRIC

____OCCLUSAL

____FMX

____PERIAPICAL

___BW

PLEASE SPECIFY AREA/TOOTH NUMBER(S) AND OTHER DETAILS:

COMMENTS:

THE BELOW SECTIONS ARE FOR OMFR USE ONLY

APPOINTMENT DATE _______________

UCONN HEALTH ID # ___________________________

OPERATOR _____________________ RADIOLOGIST ____________________

EXPOSURE: NUMBER OF IMAGES_________ NUMBER OF REPEATS _____________ TOTAL NUMBER ____________

REPORT COMPLETED DATE:____________________

COMMENTS:

INSTRUCTION TO REFERRING DENTIST:
PLEASE FILL OUT THIS FORM AND EMAIL TO omfrclinic@uchc.edu
IMAGES WITH REPORT WILL BE EMAILED TO THE DENTIST.