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

UCONN HEALTH

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

UCONN HEALTH ID # _____

APPOINTMENT DATE _____

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.