Advanced Imaging Request Form (CBCT)

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: ____

REASON FOR SCAN / RELEVANT CLINICAL HISTORY

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

TREATMENT PLANNING: [CHECK APPROPRIATE]

____TMJ EVALUATION

____TRAUMA

____ROOT CANAL EVALUATION

____IMPACTED TEETH

____SINUS EVALUATION

____ORTHODONTIC EVALUATION

____CRESTAL BONE EVALUATION

____FRACTURED TEETH

____IMPLANT ____MAXILLA ____MANDIBLE SPECIFY SITE: ____________

STENT _____YES _______NO BONE GRAFT ________YES ________NO DONOR SITE: ______________________

____OTHER: (SPECIFY LOCATION AND PROVISIONAL DIAGNOSIS BELOW)

COMMENTS:

IMAGING REQUESTED: [CHECK APPROPRIATE] CBCT FIELD OF VIEW ____ LARGE ____ SMALL [ENDODONTIC IMAGING]

THE BELOW SECTIONS ARE FOR OMFR USE ONLY

APPOINTMENT DATE _______________

UCONN HEALTH ID # ___________________________

OPERATOR _____________________ RADIOLOGIST ____________________ FOV___________

EXPOSURE: NUMBER OF SCANS_________ NUMBER OF REPEATS _____________ TOTAL NUMBER OF SCANS ____________

REPORT COMPLETED DATE: __________________DICOM/REPORT/WORKUP ARCHIVED __________________

COMMENTS:

INSTRUCTION TO REFERRING DENTIST:

PLEASE FILL OUT THIS FORM AND EMAIL TO omfrclinic@uchc.edu. PRINT A COPY AND SEND WITH PATIENT. ANY IMAGING STENTS SHOULD BE SENT WITH THE PATIENT. ALL STENTS WILL BE GIVEN BACK TO THE PATIENT. CD CONTAINING THE SCAN WITH REPORT AND WORKUP WILL BE MAILED TO THE DENTIST. IF DIGTAL TRANSFER IS AVAIALBLE DATA WILL BE SENT VIA DIGITAL TRANSFER.