

Advanced Imaging Request Form (CBCT)

Oral and Maxillofacial Radiology
UConn School of Dental Medicine
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Phone: 860-679-2718, Email: omfrclinic@uchc.edu



THIS SECTION MUST BE COMPLETED

DATE OF ORDER: _____

PATIENT'S NAME: _____

Last

First

REFERRING DR: _____

DATE OF BIRTH: _____

ADDRESS: _____

GENDER: _____

TELEPHONE: _____

ADDRESS: _____

FAX: _____

TELEPHONE: _____

EMAIL: _____

REASON FOR SCAN / RELEVANT CLINICAL HISTORY

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

TREATMENT PLANNING: [CHECK APPROPRIATE]

___ TMJ EVALUATION

___ SINUS EVALUATION

___ TRAUMA

___ ORTHODONTIC EVALUATION

___ ROOT CANAL EVALUATION

___ CRESTAL BONE EVALUATION

___ IMPACTED TEETH

___ 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 DIGITAL TRANSFER IS AVAILBLE DATA WILL BE SENT VIA DIGITAL TRANSFER.