CBCT IMAGING AND REPORTING SERVICE

UCSF Dental Center - Radiology
707 Parnassus Ave, Suite 1109 | San Francisco, CA 94143
Office: 415.476.5575 | email: dental.radiology@ucsf.edu

Cone Beam CT Referral form

Referring Doctor Information

Name: ____

Telephone No.: (   ) _______________________ Fax: (   ) ________________________________

Mailing Address: ____
Street City State Zip Code

Patient Information

Name: ___________________________________ Date of Birth: ___________

Home Address: ____
Street City State Zip Code
Telephone No.: (_____)___________________

Region and Field of View

- ❑ Maxilla
- ❑ Mandible
- ❑ Both jaws
- ❑ Limited view less than 1 jaw
  specify location___________
- ❑ Full head
- ❑ TMJ closed mouth
- ❑ TMJ open mouth

Reason for scan

- ❑ Implants
- ❑ Impaction
- ❑ TMJ
- ❑ pathology
- ❑ Sinuses
- ❑ Trauma
- ❑ Surgery
- ❑ Other- please explain

Comments on reason for scan______________

Scan options

- ❑ Scan with Stent (*patient wearing stent*)
- ❑ Scan Stent separately
- ❑ Separate jaws
- ❑ Separate lip/cheek
- ❑ Specific request- please explain

Comments on scan option______________

Image Data Output

- ❑ Report by email
- ❑ DICOM files
- ❑ Scan with viewer included
- ❑ Specific request- please explain

Comments on data output______________

Fees: Arches- $300 limited view less than 1 jaw- $200 Full head - $450

*****FOR APPOINTMENTS or QUESTIONS CALL:*** 415.476.5575 **

Please call for an appointment. Payment is required when services are rendered.

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