



## CBCT IMAGING AND REPORTING SERVICE

UCSF Dental Center - Radiology

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### CBCT interpretation Referral form

#### Referring Dentist Information

Name: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip Code

#### Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip Code

Telephone No.: \_\_\_\_\_

#### CBCT information

Date of CBCT: \_\_\_\_\_

Reason for consult: \_\_\_\_\_

Specific region of interest: \_\_\_\_\_

Relevant clinical history and findings: \_\_\_\_\_

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**CBCT interpretation report Fees: \$85.00**

For instructions on sending CBCT images for interpretation contact Dr. Rumpa Ganguly at [rumpa.ganguly@ucsf.edu](mailto:rumpa.ganguly@ucsf.edu)

**\*\*PLEASE EMAIL COMPLETED FORM TO: [rumpa.ganguly@ucsf.edu](mailto:rumpa.ganguly@ucsf.edu) \*\***