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: _____

Email: _____

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 (with or without cranium)- $345**
Limited view less than 1 jaw- $230
TMJ series (open & close mouth views)- $518

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

Please call for an appointment. Payment is required at check-in.

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