



CBCT IMAGING AND REPORTING SERVICE

UCSF Dental Center – Oral & Maxillofacial Radiology

707 Parnassus Ave, Suite 1109 | San Francisco, CA 94143

Office: 415.476.5575 | email: dental.radiology@ucsf.edu

CBCT interpretation Referral form

Referring Dentist Information

Name: _____

Email: _____

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: _____

CBCT interpretation report Fees: \$106.00

For instructions on sending CBCT images for interpretation contact
dental.radiology@ucsf.edu

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