



ADVANCED MAXILLOFACIAL IMAGING
 CENTER FOR IMPLANT & RECONSTRUCTIVE DENTISTRY
 SCHOOL OF DENTAL MEDICINE AND THE
 NEW ENGLAND MUSCULOSKELETAL INSTITUTE
 UNIVERSITY OF CONNECTICUT HEALTH CENTER
 FARMINGTON, CT 06030
 TEL: (860) 679-7600 FAX: (860) 679-7817
 conebeam.uhc.edu

CONE BEAM CT IMAGING REQUEST

REFERRING DOCTOR

PATIENT INFORMATION

DR. _____

NAME: _____

TEL: _____ DATE: _____

DOB: _____

MAILING ADDRESS:

TEL: _____

REASON FOR SCAN

RELEVANT CLINICAL HISTORY _____

IMPLANT TREATMENT PLANNING: MAXILLA MANDIBLE

SPECIFY SITES: _____

TMJ EVALUATION: LEFT RIGHT

ORTHODONTIC EVALUATION:

PATHOLOGY: (Specify location and provisional diagnosis) _____

OTHER: _____

BELOW SECTION FOR CBCT OPERATOR USE ONLY

UNIT# _____ APPOINTMENT DATE _____

OPERATOR _____ RADIOLOGIST _____

LATEX ALLERGY YES NO POSSIBILITY OF PREGNANCY YES NO

CD/REPORT MAILED _____

COMMENTS: