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
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conebeam.uchc.edu

CONE BEAM CT IMAGING REQUEST

DATE: _____ **CLINIC #** _____

EXAMINATION ORDERED BY **PROVIDER#**

FACULTY: _____ _____

RESIDENT: _____ _____

STUDENT: _____ _____

PATIENT INFORMATION

NAME: _____

DOB: _____

UNIT#: _____

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

APPOINTMENT DATE _____

OPERATOR _____ RADIOLOGIST _____

LATEX ALLERGY ☐ YES ☐ NO POSSIBILTY OF PREGNANCY ☐ YES ☐ NO

REPORT SENT _____

COMMENTS: