Request for Consult Report on Outside Patient Cone Beam CT Exam

Mail CD to:

Oral and Maxillofacial Radiology
UConn School of Dental Medicine
263 Farmington Avenue Farmington, CT 06030-2110
Phone: 860-679-2718, Email: omfrclinic@uchc.edu

UCONN HEALTH

THIS SECTION MUST BE COMPLETED

DATE OF REQUEST: _____

DR: _____

ADDRESS: _____

TELEPHONE: _____

FAX: _____

EMAIL: _____

OMFR USE ONLY

UNIT#: _____

INSTRUCTION TO REFERRING DENTIST:

PLEASE FILL OUT THIS FORM AND EMAIL TO omfrclinic@uchc.edu . UPLOAD THE DATA TO OMFR OR SEND THE DATA BY MAIL. REPORTS WILL BE EMAILED, UPLOADED, OR FAXED TO THE DENTIST.

REASON FOR SCAN / RELEVANT CLINICAL HISTORY

COMMENTS:

INFORMATION REQUIRED FOR PATIENT REGISTRATION
TO BE COMPLETED BY SUBMITTING PHYSICIAN OR DENTIST

PATIENT'S NAME: _____ SEX: _____

Last First

DATE OF BIRTH: _____/_____/_____ TELEPHONE NUMBER: _____

PATIENT'S ADDRESS: _____

Number Street

_____

City State Zip

THE BELOW SECTION IS FOR RADIOLOGIST

RADIOLOGIST _____

REPORT COMPLETED DATE: _____DICOM/REPORT/WORKUP ARCHIVED _____

REPORT DATE: _____

THE BELOW SECTION IS FOR OMFR RECORDS

REPORT SENT: DATE: _____ RECORD ROOM STAFF INITIALS: _____