SCHOOL OF DENTISTRY
UNIVERSITY *of* WASHINGTON

ORAL AND MAXILLOFACIAL RADIOLOGY
Department of Oral Medicine
1959 NE Pacific Street
Campus Box 356370, Room B317A
Seattle, WA 89195
Phone: 206.616.6061 | Fax: 206.685.8412
Email: uwomr@uw.edu

CONE-BEAM COMPUTED TOMOGRAPHY (CBCT) INTERPRETATION REQUEST

REFERRING PROVIDER INFORMATION

Full Name: ____
Practice Address: ____
City State Zip
Practice Phone: ____________________
Practice Fax: ____________________
Practice Email: ____

PATIENT INFORMATION

Full Name: ____
Date of Birth: ____
Male Female

REASON FOR SCAN/INTERPRETATION (Please select all that apply):

CBCT Image Date: ____________________
CBCT Machine (Manufacturer/model): ____

Implant(s)/Graft
Orthodontic
Endodontic
Trauma
Post Op
Other: ____________________

Guided Surgery
Impaction/Nerve Proximity
TMJ
Sinus/Airway
Pathology

AREA OF INTEREST and/or PRELIMINARY DIAGNOSIS:

RELEVANT CLINICAL HISTORY:

Thank you for your referral to University of Washington Oral Radiology Reading Service. All radiographic readings and interpretations will be reviewed by an ABOMR Certified Oral and Maxillofacial Radiologist.
Fee: $100
Please submit form via FAX to 206.685.8412 or EMAIL uwomr@uw.edu
Call 206.616.6061 to speak with an oral radiologist
Images should be uploaded via instructions listed at UW DENTAL RADIOLOGY SERVICE webpage.