SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

ORAL AND MAXILLOFACIAL RADIOLOGY
Department of Oral Medicine
1959 NE Pacific Street
Room B307
Seattle, WA 98195
Phone: 206.543.5006 | Fax: 206.685.0342
***Email: orad@uw.edu**

*Please consult our referral email policy at https://dental.washington.edu/referral-email-policy/

ENT CBCT IMAGE ACQUISITION REQUEST FORM

REFERRING PROVIDER INFORMATION

Full Name: _____
Practice Address: _____
City State Zip
Practice Phone: _____
Practice Fax: _____
Practice Email: _____

PATIENT INFORMATION

Full Name: _____
Date of Birth: _____
UWMC/HMC #: _____
Phone Number: _____
Insurance Carrier: _____ Insurance ID#: _____
RQI/Authorization#: _____ Gender: _____
Additional Info: _____

CBCT: (Please select all that apply)**:**

- ☐ Temporal Bone
- ☐ Orbits
- ☐ Maxilla
- ☐ Mandible
- ☐ Maxillary Sinus
- ☐ Frontal Sinus
- ☐ Front Sinus
- ☐ Ethmoid Sinus
- ☐ Sphenoid Sinus
- ☐ Other: _____

ADDITIONAL INFORMATION about AREA OF INTEREST and/or PRELIMINARY DIAGNOSIS:

RELEVANT CLINICAL HISTORY:

PLEASE CALL 206.543.5006 TO SCHEDULE AN APPOINTMENT. Same day imaging may be available.

Thank you for your referral to University of Washington Oral Radiology Imaging Service. All radiographic readings and interpretations will be reviewed by an ABOMR Certified Oral and Maxillofacial Radiologist.
Payment for services required prior to imaging.
Please submit form via EMAIL orad@uw.edu or FAX to 206.685.0342
Call 206.616.6061 to speak with an oral radiologist
Clinic location and directions can be found at UW DENTAL RADIOLOGY SERVICE webpage.

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