AUGUSTA UNIVERSITY
DENTAL COLLEGE OF GEORGIA

Department of Diagnostic Sciences
Cone Beam Computed Tomography referral request

Date:_____
Referring Office: _____
Address:

_____
_____

Phone: _____
E-mail: _____

Patient's Name: _____
Patient's D.O.B.: _____
Patient's Address:

_____
_____

Patient's Phone Number _____

Area of Interest: _____

Is there a radiographic guide? (yes or no) _____

Will the data be used with any 3rd party software such as Simplant, Nobel, etc.?
Specify _____

How would you like to receive the CBCT study? (DICOM files only or DICOM files with software) _____

Relevant medical/dental history:

_____
_____
_____
_____
_____

_____
Referring Dentist
Phone: (706) 721-2607
Fax: (706) 723-0201
Return form via fax or electronically through secure shared box folder