LSU Health NEW ORLEANS School of Dentistry

Faculty Dental Practice
Oral & Maxillofacial Radiology
1100 Florida Avenue, Box 8 ◆ New Orleans, LA 70119
Telephone (504) 941-8449 ◆ Fax (504)941-8336

CBCT Reading Service Referral Form

Referring Provider

Referring Doctor (First and Last): _____

Address: _____ City/State/Zip: _____

Telephone: _____ Fax: _____
(Provide number to send results)

Email address: _____

Required Patient Information

◯ Female ◯ Male

_____ Last name _____ First name _____ Middle initial or name

Date of Birth: |__|__|/|__|__|/|__|__|__|__| Age: _____

Reason for imaging study: _____
_____
_____

Payment Information

Referring clinician is responsible for charges.

Authorizing signature: _____
(Person responsible for payment)

Authorization date: _____

Instructions for Submission

1. Submit CBCT scan as DICOM files only
2. Scans need to be sent on CD or Flash Drive.
3. Send scans and referral form to the address at the top of this sheet

Record number: _____
Date Received: _____
(For LSU Radiology use only)