AUGUSTA UNIVERSITY
DENTAL COLLEGE OF GEORGIA

Department of Oral Biology and 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 Phone Number _____

Radiology Report:
☐ General overread to rule-out pathology

☐ Specific area of interest:

_____
_____
_____

Relevant medical/ dental
history: _____
_____
_____

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