Department of Diagnostic Sciences
PO Box 9465 Morgantown, WV 26506
Phone: 304-293-4659
Email: sodreferrals@hsc.wvu.edu

Please email the completed form to sodreferrals@hsc.wvu.edu.

Payment is required when services are rendered.

# CBCT and Image Radiology Reading Service Referral Form

**Referring Provider**

Name (First and Last): _____ Phone: _____

Address: _____ Fax: _____

**Patient Information**

Name: _____ Date of Birth:_____ Sex: ___

Home Address:_____

Phone: _____

**Payment Information**

*Referring clinician is responsible for charges.*

Authorizing signature of person responsible for payment:_____

Authorization date: _____

**CBCT information**

Date of CBCT: _____

Reason for consult: _____

Specific region of interest: _____

**Instructions for Submission**

Submit CBCT scan as DICOM files only.

Scans need to be sent on CD or Flash Drive.

Send scans and referral form to the address above.

Record number: _____

Date Received: _____

(For WVU Dental Radiology use only)