CT INTERPRETATION

University of Pittsburgh
Oral and Maxillofacial Radiology
G-119, Salk Hall
3501 Terrace St
Pittsburgh 15213

E-mail completed form to:
anp60@pitt.edu
or fax to: (412) 383-9142

Patient Name:_____

Address:_____
_____

Date of Birth:_____/_____/_____

Sex: Male ☐ **Female** ☐
Doctor:_____

GP ☐ **Endo** ☐ **ENT** ☐ **OS** ☐

Ortho ☐ **Pedo** ☐ **Perio** ☐ **Other** ☐

Address:_____
_____

Phone: _____

Fax: _____

E-mail: _____

Today's Date:_____ **Exam Date:** _____

TO BE COMPLETED BY PHYSICIAN/DENTIST

Pertinent History: _____
_____
_____

Signs, Symptoms, Relevant clinical information and any previous images:
_____
_____
_____
_____

Physician/Dentist (Print):

_____

Physician/Dentist Signature:

_____