School of DENTISTRY
Oral & Maxillofacial Radiology

Imaging Interpretation Services
Dr. Saulo Sousa Melo, Director
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503-494-8930

Interpretation Referral Form

Patient:		**Sex:** M / F / U	**Date of birth:**
Doctor:		**Email:**	
Practice:		**Phone:**	
Address:		**State:**	**Zip code:**

Reason for exam: (check all that apply)

____ Implant planning ____ Tooth extraction ____ TMJ
____ Bone graft ____ 3rd molar ____ Paranasal sinuses
____ Pathology ____ Impacted tooth ____ Endodontics
____ Other, please describe: _____

Inquiry:

Relevant history:

Select a dataset delivery method:

___ USPS mail — Please send media (CD, DVD, or flash drive) with the DICOM files and a copy of this form to:
Dr. Saulo L. Sousa Melo - OHSU School of Dentistry
2730 SW Moody Ave SD-RAD, Portland, OR 97201

___ BOX drive — On your CASES folder*, create a folder with patient's name and date of birth (e.g.: John Doe 01-01-2020). Add DICOM files to that folder. Add a copy of this form to the REFERRAL FORMS folder.
**Should this be your first time, please call us at 503-494-8790 to set up your BOX drive.*

Report Fee: **$ 85.00**
Fee will be invoiced to the referring doctor. Payment instructions will be provided.
OHSU will not bill patient directly for any reading. This is a service agreement between OHSU and referring doctor.

Select a report delivery method: ____ Secure E-Mail ____ BOX drive ____ USPS mail

Signature of Referring Doctor: _____ **Date:** _____