School of DENTISTRY
OHSU

Imaging Interpretation Services
sodrad@ohsu.edu | 503-494-8930

Interpretation Referral Form

Patient and referring doctor information			
Patient:		**Sex:** ☐ M ☐ F ☐ U **Date of birth:**	
Doctor:		**Email:**	
Practice:		**Phone:**	
Address:		**State:**	**Zip code:**

Reason for exam		
☐ Implant planning	☐ Tooth extraction	☐ TMJ
☐ Bone graft	☐ 3rd molar	☐ Paranasal sinuses
☐ Pathology	☐ Impacted tooth	☐ Endodontics
☐ Other, please describe:		

Inquiry

Relevant history

Dataset delivery method

Select one delivery method for the DICOM dataset.

Dataset delivery options	
☐ USPS mail	Please send media (CD, DVD, or flash drive) with the DICOM files and a copy of this form to: OHSU School of Dentistry - Radiology Department 2730 SW Moody Ave SD-RAD, Portland, OR 97201
☐ Cloud (Microsoft OneDrive)	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 OneDrive folder.*

Report fee

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

Report delivery method

Report delivery options		
☐ Secure E-Mail	☐ OneDrive	☐ USPS mail

Authorization			
Signature of Referring Doctor:		**Date:**	