CAROLINA
NeuroSurgery & Spine
ASSOCIATES

CT Patient Screening Form

Exam Date _____/_____/_____ Ordering Physician_____ MR# _____

Name _____ Date of Birth _____/_____/_____ ☐ Male ☐ Female
Last name First name Middle Initial MM / DD / YY (check one)

Weight_____ lbs.

Describe your symptoms: _____

_____

(symptoms continued)

Prior exams:

Have you had prior diagnostic imaging study on area being scanned today (MRI, CT, X-ray, Ultrasound, etc.)? ☐ **YES** ☐ **NO**

If yes, please list type of exam(s), body part, date of exam and facility: _____

_____

Yes	No	
☐	☐	Have you ever had cancer? If YES, what type and when? _____
☐	☐	Have you had radiation treatments? If YES, when was your last treatment? _____
☐	☐	Have you had chemotherapy? If YES, when was your last treatment? _____
☐	☐	Have you had a recent fever or infection? Please explain_____

Any recent surgery on area being scanned today? _____Date _____

For female patients:

Are you pregnant or experiencing a late menstrual period? ☐ **YES** ☐ **NO**

Date of last menstrual period: _____/_____/_____ Post-menopausal? ☐ **YES** ☐ **NO**

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I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the CT procedure I am about to undergo.
I hereby authorize Carolina Neurosurgery & Spine Associates, P.A. to release insurance information to Charlotte Radiology for billing purposes associated with the interpretation /reading of my CT examination. I understand that I will receive two separate charges for this procedure; one for the CT examination and one for the interpretation/reading of today's scan.

Signature_____ Date _____

Relationship to patient _____

Technologist Signature _____ Date _____