CAROLINA
NeuroSurgery & Spine
ASSOCIATES

CT Brain Non-Contrast Patient Screening Form

Date_______________ **Male/Female** **MR#**______________________

Name____ **DOB**____/____/____
Last **First** **MI**

Ordering Physician____________________________________ **Weight**_________________

Have you had a previous CT or MRI scan of your Brain? YES/NO (If YES where and when):

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What, if any symptoms or problems are you having now: ________________________________

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Have you had Brain Surgery: YES / NO

If Yes: When_____________ **Reason for Surgery**______________________________________

***For Female Patients*: Date of Last Menstrual Period ____/____/_____**
Are you Pregnant: Yes / No
Post Menopausal: Yes / No
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I attest that the above information is true to the best of my knowledge. I have read and understand the contents of this form and have the opportunity to ask questions regarding the CT exam I am about to undergo.
I hearby authorize Carolina Neurosurgery & Spine Assoc. to release information to Charlotte Radiology for billing purposes associated with the interpretation (reading) of my CT examination. I understand that I will receive two seperate charges for this procedure: one for the CT exam and one for the CT interpretation/reading.

Signature______________________________________**Relationship to Pt.**__________________________
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Technologist Signature__________________________________**Date**______________________________

Diagnosis____