PathFinder Brain SPECT

at the Neuroscience Center
440 Lake Cook Road, Deerfield, IL 60015. Tel (847) 945-7284. FAX: (847) 945-7286.

Requisition for Brain SPECT

Patient's Name: _____ Age _____
Date of Request: _____
Patient's Phone (Home) _____
(Mobile) _____

Referring Professional _____ **Signature** _____

Referring Physician Office Phone No. _____

Has the Patient had any other recent pertinent test □ Yes □ No
If Yes, please list which one and last date: EEG, Neuropsychology testing, MRI, previous Brain SPECT or Brain PET,

_____

_____

□ Brain SPECT functional imaging (perfusion)

Clinical reason(s) for Brain SPECT request:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Present Medication:

Scheduling information:

1. Send by **FAX** this requisition form to **(847) 945-7286:** We will call the patient and schedule.
2. For short term schedule or if the patient is unreliable, call (847) 945-7284 **but please follow-through with a FAX** of this requisition.

VER 5-11-05