

PathFinder Brain SPECT, LLC

at The Neuroscience Center

440 Lake Cook Road, Deerfield, IL 60015, Suite #3 OFF: (847) 945-7284 FAX: (847) 236-9411.

Requisition for Brain SPECT

Patient's Name: _____ Date of Birth: _____
Date of Request: _____ Age: _____
Patient's Phone (Home) _____ Preferred date(s): _____
Patient's Phone (Cell) _____

Referring Physician: _____ **Signature:** _____

Referring Physician Office Phone: _____

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 (perfusion)

Clinical reason(s) for Brain PET or SPECT request:

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

Present Medication:

Scheduling information:
1. Send by **FAX** this requisition form to **(847) 236-9411**: We will call the patient and schedule.
2. For urgent scheduling or, if the patient is unreliable, call (847) 945-7284 or (847)236-9310 **but please follow-through with a FAX** of this requisition.