PROVIDERS: Please fill out this form and fax it to (866) 433-3965 before giving a copy to the patient.

BRAIN IMAGING:

(Please add pertinent medical history below)

- ☐ Brain SPECT (78607)
- ☐ Brain SPECT w/ CT (78607/70450)

INDICATION *(Check all that apply)***:**

- ☐ ADD-ADHD (F90.9)
- ☐ Alzheimer's disease (G30.9)
- ☐ Anxiety Disorder (F41.9)
- ☐ Ataxia (I69.393)
- ☐ Bipolar Disorder (F31.9)
- ☐ Depression (F32.9)
- ☐ Mild Cognitive Impairment (G31.84)
- ☐ Toxic Encephalopathy (G92)
- ☐ TBI (S06.2X0A)
- ☐ TBI with LOC (S06.2X9A)
- ☐ PTSD (F43.10)
- ☐ Seizure (G40.89)
- ☐ Stroke (G46.4)
- ☐ Other:______________________________

IMAGING LOCATION:

- ☐ Chicago, IL
- ☐ Dallas-Fort Worth, TX
- ☐ Denver, CO
- ☐ Florence, AL
- ☐ Houston, TX
- ☐ Naples, FL
- ☐ New Orleans, LA
- ☐ New York, NY
- ☐ Phoenix, AZ
- ☐ San Diego, CA

HISTORY & DIAGNOSIS

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PATIENT INFORMATION:

Name

Date of Birth *Female/Male*

Home Phone # *Alternate Phone #*

Parent/Guardian (if patient is a minor)

Height *Weight*

Email

How would the patient like to receive their scan results?
☐ EMAIL ☐ FAX ☐ MAIL (hard copy)

ORDERING PROVIDER:

Name *NPI*

Clinic Name

Specialty

Phone # *Fax #*

Email

Address

Address 2

City *ST* *Zip*

How would you like to receive the patient's scan results?
☐ EMAIL ☐ FAX ☐ MAIL (hard copy)

Signature *Date*