Center for NEUROSCIENCES

Brain Tumor Center
External Imaging Review Form

Patient Name: _____ Date: _____

Address: _____
Street City State Zip Code

Phone Numbers: _____
Cell Home Work

Have you had brain/spine surgery? ❒ **Yes** ❒ **No**

If yes, please provide the following information:

Institution where surgery was performed: _____

Date(s) of surgery: _____

Please include a copy of any pathology reports.

Have you had previous brain imaging? ❒ **Yes** ❒ **No**

If yes, please provide the following information:

Radiology facility: _____

❒CT ❒MRI *(mark one or both if appropriate)*

Dates of imaging: _____

Have you ever had chemotherapy? ❒ **Yes** ❒ **No**

If yes, please provide the following information:

Name of chemotherapy drug: _____

Institution where the chemotherapy was administered: _____

Date(s) chemotherapy was administered: _____

Have you ever had radiation therapy? ❒ **Yes** ❒ **No**

If yes, please provide the following information:

Institution where radiation therapy was administered: _____

Date(s) radiation therapy was administered: _____

Before mailing, please be sure to include all of the follow items:

❒ Completed External Imaging Review Form

❒ Payment ($100) payable to Center for Neurosciences

❒ MRI Studies (preferably at least two)

❒ Pathology Reports