☐BRANDYWINE
☐OMEGA IMAGING
☐PIKE CREEK
☐GLASGOW

C.T.REQUEST: NECK/SPINE

Patient#: _____ Date: _____

Name of Patient: _____ Age: ____ Date of Birth: __/__/__

Requesting Doctor: _____ Family Doctor: _____

Why do you need this test?: _____

POSSIBILITY OF BEING PREGNANT: ☐NO, ☐YES, Date of last menstruation:_____

CLINICAL INFORMATION:

Check if Yes		Side Left	Side Right
☐	Neck mass	☐	☐
☐	Neck pain	☐	☐
☐	Neck swelling	☐	☐
☐	Pain/numbness in arm	☐	☐
☐	Upper Back Pain	☐	☐
☐	Lower Back Pain	☐	☐
☐	Leg Pain , which side ?	☐	☐
☐	Leg Numbness , which side ?	☐	☐
☐	Cold Leg/foot , which side ?	☐	☐
☐	Cramp when walking	☐	☐

ALLERGIES: ☐ Yes , ☐No
Type: _____

Heart Problems ☐Yes , ☐No
Kidney Problems ☐Yes , ☐No
Asthma ☐ Yes , ☐No
Allergy to X-ray Dye. ☐Yes , ☐No

ADDITIONAL PERTINENT INFORMATION:
_____
_____
_____

SPINE OR NECK INJURY: (give details if known)

Neck or Back injury : No____, Yes____ , date: _____
Place: _____

Previous neck or back Surgery: (disc, fusion...)
No____, Yes____ , Which area of the spine?: _____ date: _____

Any Known Tumor? ☐ No , ☐ Yes : What part of the body: _____
Any other Surgery? ☐No , ☐ Yes : What part of the body: _____

PREVIOUS EXAMINATIONS : (give dates and places if known)

	Check if YES:	Date:	Where?
MRI of Spine	☐	/ /	_____
C.T. of Spine	☐	/ /	_____
Spine X-rays	☐	/ /	_____
Myelogram	☐	/ /	_____
Nuclear Medicine Bone Scan	☐	/ /	_____
E.M.G.	☐	/ /	_____
Others, specify:	☐		

Technologist: _____,R.T.