



Providers: please fill out this form and fax it to 866-433-3965 before giving a copy to the patient.

Patient Information:

Name: _____ DOB: _____

Male Female

Parent/Guardian (if patient is a minor): _____

Home Phone #: _____ Alternate Phone #: _____

Brain SPECT Imaging – Single Photon Emission Computed Tomography

Diagnosis/Clinical Indications: _____

Name of Ordering Provider: _____ NPI #: _____ (required)

Phone #: _____ Fax #: _____

Address: _____

Signature: _____

Please note: Cancellations must be made 72 business hours in advance.

As part of our regular service to patients, CereScan offers to our patients a one-hour educational review of the patient's images and report conducted by a Master's level clinician who is highly trained and supervised by our reading physicians. If you have any questions or concerns about this educational review, please contact Julie Banta, VP of Provider and Patient Care at 720-242-9081.

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