MRI/MRV Brain/Head

_____Brain/Brain with or without contrast **_____ Head** **_____ Orbits**
_____Pituitary **_____Acoustics** **_____ECA/ICA**
_____Sinuses

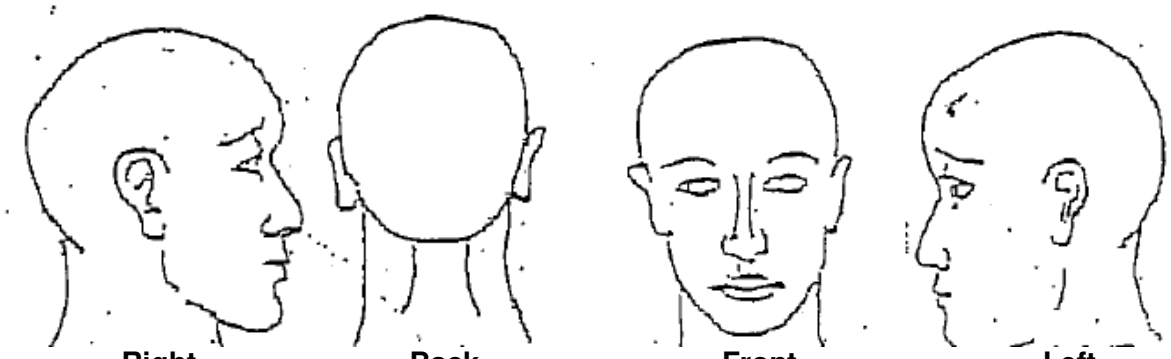
Name		Acct #		Date	

What problems have you been having?			
How long have you had them?			
Have you had other tests for this problem?			
Medical Problems			
Did you take any medication for sedation or to relax you today?		No	Yes
If yes, what?			

Do you have any of the following (circle any that pertain)

Stroke	Lightheadedness	Head injury	Dizziness	Numbness
Hearing changes	Passed out	Weakness	Cancer	Nausea
Visual changes	Headaches	Vomiting		

Please shade in area(s) affected by pain or numbness



Date _____Patient Signature _____/Signature of patient's representative_____
(Relationship: __ Parent (minor under 18 years) __Court appointed Guardian)

Technician Review & Signature_____

Fax to Premier MRI/CT: 800.792.6950