CEDARS-SINAI MEDICAL CENTER®
Alder/Nail and Cedars-Sinai Research for Women's Cancers P.E.T. Center

BRAIN PET REFERRAL FORM

Appointment Scheduling: 310-423-8000 and press 1

Fax all orders to: 310-423-0137

Patient Name: ______________________________ Date of Birth: ________________

Is Patient Diabetic? ☐ Yes ☐ No Reservation Number: ________________

Indication:

☐ **Alzheimer's and Fronto-temporal Dementia**; Brain
☐ **Refractory seizures**
☐ **Other:** ____
____

Mini mental status exam (MMSE) or similar testing: Score: __________ Date: ________________

Summary of reports from neuropsychological testing performed: ________________________

Structural imaging: ☐ MRI ☐ CT Date: ________ Where performed: ________________________

Name of neurological medications : ____

Previous SPECT or FDG-PET scan for same indication: ☐ Yes ☐ No If Yes, Date: ________________

SYMPTOMS: ____
____

Date of onset**:** ________________________

REFERRING PHYSICIAN NAME: ____
PLEASE PRINT

PHONE: ______________________________ **FAX:** ______________________________

REFERRING PHYSICIAN SIGNATURE: ______________________________ **DATE:** ________________

www.cedars-sinai.edu/imaging

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