PRE-FIGHT BRAIN CT SCAN INTERPRETATION FORM

NOTE: Only a licensed radiologist, neurologist or neurosurgeon may complete this form

NAME: _____ **EXAM DATE:** _____

ADDRESS:
_____

CITY: _____ **STATE:** _____ **COUNTRY:** _____

PHONE: _____ **DATE OF BIRTH:** _____

TYPE OF MRI CONDUCTED?
_____

***IS THIS CT EXAMINATION WITHIN NORMAL LIMITS?** ☐ **YES** ☐ **NO**

IS FURTHER REFERRAL OR EXAMINATION NEEDED? **YES** ☐ **NO**

IF SO, FURTHER RECOMMENDATIONS INCLUDE:

_____

_____

_____

BASED ON THIS CT, THE FIGHTER:

IS **IS NOT** **MEDICALLY CLEARED TO PARTICIPATE**

Physicians Name:
_____

Physician Signature:
_____

Address: _____ City: _____

State: _____ Country: _____ Zip: _____

Phone: _____ Fax: _____

***PLEASE INCLUDE A COPY OF THE ACTUAL CT EXAMINATION REPORT WITH THIS FORM**