CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

PEDIATRIC BRAIN -- TUMOR MEDICAL HISTORY FORM FOR OUTSIDE SCAN REVIEW PROGRAM

PATIENT INFORMATION:
Name : LAST_____ FIRST_____Age: _____ Male ☐ Female ☐ DOB:___/___/____

Address: _____ City_____ State _____ Zip Code: _____

Family Contact: _____ Relationship: _____ Patient SS#_____

Phone: (Day)_____(Evening)_____(Fax) _____(Email)_____

PRIMARY CARE PHYSICIAN:
LAST_____ FIRST_____

Address: _____ City_____ State ____ Zip Code: _____

Phone: _____Fax: _____ Email: _____

PATIENT'S INITIAL NEUROLOGICAL DEFICITS, SYMPTOMS, AND COMPLAINTS:
- _____

PATIENT'S CURRENT NEUROLOGICAL DEFICITS, SYMPTOMS, AND COMPLAINTS:
- _____

IMAGING STUDIES, i.e. MRI, CT, PET [Specify Type, Findings and Date(s)]:
- _____

DIAGNOSIS: Date of Diagnosis: _____ Right Handed ☐ Left Handed ☐

Current Date(s) of Tumor Progression/Recurrence:
- _____

PRIOR TREATMENT:	**Yes**	**No**	**If Yes, Please provide Date(s) Performed:**
Surgery			
Open biopsy	☐	☐	_____
Stereotactic biopsy	☐	☐	_____
Tumor Removal & Percentage Removed	☐	☐	_____
Radiation therapy			
External/Focused beam	☐	☐	_____
Whole brain	☐	☐	_____
Neuroaxis	☐	☐	_____
Chemotherapy	☐	☐	If yes, please list names and dates of therapies/drugs: _____
Clinical Trials	☐	☐	If yes, please list names and dates of therapies/drugs: _____
Genetic Studies	☐	☐	If yes, please list names and dates: _____
Alternative therapies	☐	☐	If yes, please list names and dates: _____

PREVIOUS RECOMMENDATIONS ?
- _____

WHAT IS/ARE THE MOST IMPORTANT QUESTION(S) YOU WANT US TO ANSWER?
- _____

HOW DID YOU HEAR ABOUT US? Magazine Article ☐ Internet ☐ Cedars/MDNSI Website ☐
Physician referral ☐ Friend ☐ Radio Ad ☐ Other ☐ _____(revised 01/02)

Scan Reviews being sent from outside of California and Michigan, must be filled out, submitted& signed below by a referring MD:

_____ _____ _____ _____
Treating Physician Name (Printed) Treating Physician Signature State Date