MOHEGAN TRIBE
DEPARTMENT OF ATHLETIC REGULATION

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