Patient Care Coordinator: ____________________ **Phone:** _________________

Enclosed, please find a packet of information, questionnaires, and policy statements concerning your brain scan. The contents of this packet are:

- Patient/Guardian Agreement pg. 2-3
- Cancellation Agreement pg. 4
- Patient Information and Clinical History pg. 5-11
- Release of Information Form pg. 12
- Patient Instructions pg. 13
- Frequently Asked Questions pg. 14-15
- Driving Directions and Map pg. 16

Please read, complete and sign the paperwork where indicated. Pages 2 -12 are due in our office at least 5 days prior to your first appointment. Pages 13-16 are for you to keep. If you have any questions, please contact your Patient Care Coordinator at the number listed above.

_____Return the forms in the enclosed envelope(s) by_____________

_____Fax the forms to our clinic at 866-433-3965 by______________

Appointment information:
A 30-minute telephone intake appointment will be scheduled prior to your first scan during which our clinician will go over your completed paperwork and may ask you additional relevant questions. Each scan appointment will last approximately 2.5 hours, and the scan appointments will take place approximately 2 days apart. A final appointment will occur after the reading physician has completed your report. At this time you will meet with our clinician to review your brain scan report and images. This meeting can take place at our clinic, via web conference or by conference call. You are welcome to invite family members, treating professionals (physician, therapist, etc) or members of your support system to attend the review with you. The review appointment will take about 1 hour.

If you are **ALLERGIC to PLASTIC,** please call us immediately.

Thank you!

PATIENT / GUARDIAN AGREEMENT

CLINIC HOURS

CereScan's hours of operations are from 9:00 a.m. to 5:00 p.m., Monday through Friday.

PRE-SCAN FLUID CONSUMPTION REQUIREMENTS

It is important to be fully hydrated before your scans. We recommend that in the 24-hour period prior to each scan, adult patients drink 6-8 glasses (36-48 ounces) of non-caffeinated fluids and children consume 3-4 glasses (18-24 ounces) of non-caffeinated fluids. If you are not from Colorado, you may experience greater thirst than normal while in Denver, thus it will be important to increase your non-caffeinated fluid consumption even more during your stay. **Please note that inadequate fluid consumption may prevent the patient from being injected and scanned, and therefore may result in the forfeiture of your deposit.**

APPOINTMENTS

Appointments are made with a Patient Care Coordinator by the patient or the patient's guardian. **A deposit of $500.00 is required in order to schedule an appointment and is refundable until 3 business days before the first scan appointment. Scan appointments that are missed or cancelled 3 business days or less before your scheduled appointment will result in your loss of the $500.00 deposit. If a scan cannot be performed due to patient non-compliance with the patient instructions on page 13, the $500.00 deposit will be forfeited and your scan will have to be rescheduled.**

EQUIPMENT RELATED RISKS

CereScan's functional brain imaging camera is highly technical equipment. The equipment occasionally requires unexpected maintenance. If this should occur, it could become necessary to reschedule your appointment. Please note: CereScan is not responsible for reimbursing any travel or other expenses due to rescheduling of your appointment because of unexpected equipment maintenance.

PHYSICAL REQUIREMENTS

The patient's head must remain motionless (blinking eyes and swallowing are o.k.) for approximately 30 minutes during the scan process. If you have any concerns about the patient's ability to keep his/her head motionless, please contact your Patient Care Coordinator at 866-722-4806 immediately.

PREGNANCY/LACTATION

This evaluation carries a potential risk of birth defects to a developing fetus. **I certify that I am not pregnant. Additionally, if I am breast-feeding, I have requested, received, and read the document, *Policies and Instructions for Patients who are Breast-feeding*.** _______
Initial

CHILDCARE POLICY

Our clinic offers a children's area with quiet activities for younger patients and family members. However, since we do not have staff available for childcare, it is the parent/guardian or adult patient's responsibility to provide supervision or childcare for their children while at our clinic. Young children will not be allowed in the camera room during your scan, therefore you must have another adult available to supervise them during your brain scan.

PATIENT / GUARDIAN AGREEMENT (continued)

FINANCIAL AND OWNERSHIP RELATIONSHIP

CereScan's goal is to establish an atmosphere of mutual trust and understanding between our patients and our office. Therefore, please discuss fees and payments with your Patient Care Coordinator at any time. For your convenience, we accept major credit cards (American Express, Visa, MasterCard and Discover). It is our policy to collect all fees incurred for the services provided to you. A $45.00 service fee is charged for each returned check. You will be given a copy of your brain scan report and a second copy will be mailed to your referring physician. Additional copies of your report are available for a fee. While the medical information belongs to the patient, CereScan retains a copyright in all of its images and reports, which may not be used for any purpose other than the communication of medical information for and on behalf of the patient.

INSURANCE

While we do not direct bill insurance companies, we can provide you with a coded superbill to submit to your insurance company for any out-of-network benefits that may be available to you.

DISCLOSURE STATEMENT

While CereScan will exercise its best efforts to maintain and protect the confidentiality of the information related to the services provided under this Agreement, please understand that we may be required by a court of law to disclose the information you provide us and information concerning the services we provide you. We are also obligated by law to report any suspicions we may have of child abuse or neglect, and information which may indicate a threat of imminent violence against another, to oneself, or to national security.

DIAGNOSTIC INFORMATION

The information from your functional brain scan report will be used by your doctor to support a conclusion about your condition or assign a diagnosis. CereScan does not assign you the diagnosis.

I have read, fully understand, and agree to the terms of this Patient/Guardian Agreement.

____________________________________ ________________________

Patient or Guardian Signature **Date**

____

Please print name

Thank you for choosing CereScan. We look forward to working with you.

Cancellation/Missed Appointment Fee Agreement

Date __________________ **MR#**___________ (for office use only)

Responsible Party Name:_______________________________________

Social Security Number:__________-________-__________

Relationship to patient: _______________________________________

Address ____

City ______________________ **State** ______________ **Zip** _______

Phone __________________________ **Cell** __________________

In consideration for functional brain imaging services performed on behalf of (Patient's Name) ________________________, I (Responsible Party) ________________________ promise to pay $500.00 to CereScan in the event that, for any reason, any of the appointments are missed or cancelled within 72 business hours, or are unable to be performed due to lack of patient compliance with the scanning instructions. Please call 866-722-4806 to cancel or reschedule your appointment.

I understand and agree that the following account will be automatically charged:

CREDIT CARD DRAFT (Please circle one)

Visa MasterCard American Express Discover

Card number__________/______________/______________/__________

Expiration Date: _______/__________ **Verification code:** ______________

Billing address if different from above:

Address ____

City ______________________ **State** ______________ **Zip** _______

______________________________ ____________________

Responsible Party Signature **Date Signed**

PATIENT INFORMATION (please print)

Last Name ___________________________ First Name__________________________ M.I.___________

Mailing Address ____

City ____________________________________State ____________ Zip Code _______________________

Date of Birth __________________ Age _______SS#______________________ Marital Status ___________

Male ______ Female______ Home Phone _____________________ Cell Phone ______________________

Fax ____________________________ E-mail ____

Employer ____Work Phone _____________________________

Occupation ____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

____Home telephone # ______________________

_____ Leave message with detailed information _____ Leave call-back number only

____Work telephone # ______________________

_____ Leave message with detailed information _____ Leave call-back number only

____Cell phone # __________________________

_____ Leave message with detailed information _____ Leave call-back number only

____Fax # _______________________________

____Written Communication Only - to this address: ____

Information about me may be communicated with the following people:

Full name	Relationship to patient

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. **NOTE: Uses and disclosures for the Privacy Officer may be permitted without prior consent in an emergency.**

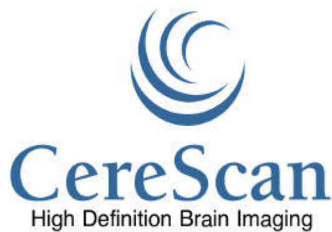
EMERGENCY CONTACT (spouse, friend or relative who can be reached in case of emergency)

Person's Full Name ____

Relationship to Patient____

Address ____City_________________________________

State _________________________________Zip____________ Telephone # ________________________



REFERRING PHYSICIAN INFORMATION

Name ____ Specialty _______________________________

Address ___________________________________City _________________ State ____ Zip _______________

Phone _______________________________________ Fax ____

PRIMARY CARE PHYSICIAN INFORMATION (if different from referring physician)

Name ____ Specialty _______________________________

Address ___________________________________City _________________ State ____ Zip _______________

Phone _______________________________________ Fax ____

HOW DID YOU HEAR ABOUT CERESCAN?

Doctor or Treatment Professional (name) ____

Internet/Website ____ Television program ____ Print Ad ____ Radio Ad ____ Acquaintance ____ Self ____

Conference (organization) ____________________ Attorney (name) _____________________ Other ____

ACCIDENT INFORMATION (if applicable)

If Patient's condition is related to an accident, please indicate the nature of the accident:

Employment _____ Auto Accident _____ Other (explain) ____

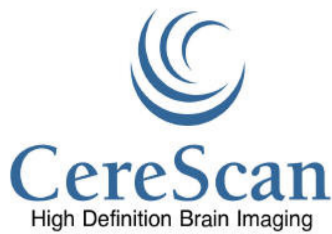
Date of Accident ________________ Attorney Name (if applicable)_______________________________________

Release

I hereby authorize CereScan to release to my Referring Physician a copy of my medical records. I understand that a re-billing fee/finance charge complying with Colorado State Law may be applied to any overdue balance on my account with CereScan. I agree to pay any costs CereScan incurs for pursuing collection of my bill including, not limited to, all court costs and reasonable attorneys' fees. I also agree that all images and medical reports generated for and on behalf of me at CereScan will become part of CereScan's expanding proprietary database for ongoing scientific research into neurological and neurobehavioral disorders. I hereby authorize CereScan to use and replicate all medical information contained in the images and reports for proprietary research, training, teaching or any other purpose deemed appropriate by CereScan. All identifying data will be removed from all images and medical reports prior to inclusion in the database to protect my privacy.

Signature ____**Date** __________________________

Print Name ____



Patient Clinical Information and History

Primary reason(s) for getting a brain scan:

____

Handedness: ☐ right-handed ☐ left-handed

Racial/Ethnic group you identify with: ______________________________

If Female: Are you pregnant or nursing? ☐ Yes ☐ No

Please check any of the following symptoms you have:

☐ Confusion
☐ Cognitive function problems
☐ Cognitive decline or changes
☐ Long-term memory problems
☐ Short-term memory problems
☐ Difficulty integrating information
☐ Difficulty learning new things
☐ Difficulty performing familiar tasks
☐ Problems with language/word finding
☐ Disorientation to time and/or place
☐ Decreased judgment
☐ Problems with abstract thinking
☐ Personality changes
☐ Anger management problems
☐ Impulse control problems
☐ Difficulty with concentration
☐ Difficulty following instructions
☐ Problems paying attention
☐ Losing things
☐ Making careless mistakes
☐ Distractibility
☐ Disorganization
☐ Restlessness/Fidgetiness
☐ Low frustration tolerance
☐ Suicidal thoughts

☐ Excessive sadness
☐ Loss of appetite
☐ Increased appetite
☐ Insomnia
☐ Sleeping too much
☐ Fatigue
☐ Inappropriate guilt
☐ Grief
☐ Loss of interest in things
☐ Loss of motivation
☐ Self-mutilation (cutting)
☐ Paranoia
☐ Delusions
☐ Hallucinations
☐ Psychotic episodes
☐ Risky behavior
☐ Mood swings
☐ Irritability
☐ Elevated mood
☐ Need less sleep
☐ Talkativeness
☐ Racing thoughts
☐ Promiscuity
☐ Increased energy
☐ Suicide attempt(s)

☐ Worry
☐ General anxiety
☐ Panic attacks
☐ Social anxiety
☐ Performance anxiety
☐ Compulsive behavior
☐ Obsessive thoughts
☐ Flashbacks of trauma
☐ Nightmares
☐ Frequent headaches
☐ Frequent dizziness
☐ Fainting spells
☐ Balance problems
☐ Blurred or double vision
☐ Ringing in ears
☐ Nausea
☐ Gastrointestinal problems
☐ Urinary problems
☐ Involuntary tics
☐ Tremors
☐ Hot flashes
☐ Sensory problems
☐ Muscle spasms
☐ Muscle pain
☐ Suicide plans

CereScan
High Definition Brain Imaging

Diagnoses
Please check the boxes of any diagnoses that you have been given by a doctor or treatment provider.

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asperger's disorder
- ☐ Autism
- ☐ Autoimmune disorder
- ☐ Back injuries
- ☐ Bipolar spectrum disorder
- ☐ Birth deformities
- ☐ Bleeding problems
- ☐ Blood transfusions
- ☐ Borderline personality disorder
- ☐ Brain injury
- ☐ Brain tumor
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Cholesterol abnormalities
- ☐ Chronic pain
- ☐ Conduct disorder
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Headaches (migraine)
- ☐ Headaches (tension)
- ☐ Hearing problems
- ☐ Human immune virus (HIV)
- ☐ Hypertension
- ☐ Inhalant abuse
- ☐ Kidney disease
- ☐ Learning disorder
- ☐ Liver disease
- ☐ Lupus
- ☐ Lyme disease
- ☐ Menopause
- ☐ Mental retardation
- ☐ Multiple sclerosis
- ☐ Neck injury
- ☐ Obsessive compulsive disorder
- ☐ Oppositional defiant disorder
- ☐ Panic attacks
- ☐ Parkinson's disease
- ☐ Posttraumatic stress disorder
- ☐ Prescription drug abuse
- ☐ Schizophrenia
- ☐ Seizure disorder
- ☐ Sexually transmitted disease
- ☐ Sleep apnea
- ☐ Social phobia
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid problems
- ☐ Tic disorder
- ☐ Transient ischemic attack (TIA)
- ☐ Other:______________________

History of Possible Brain Injury (please provide date and brief description of occurrence):

Motor vehicle accident or other impact injury to the head:

1.____
☐ with head impact ☐ loss of consciousness
☐ without head impact ☐ post-injury confusion or headaches

2. ____
☐ with head impact ☐ loss of consciousness
☐ without head impact ☐ post-injury confusion or headaches

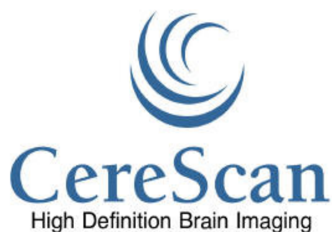
3. ____
☐ with head impact ☐ loss of consciousness
☐ without head impact ☐ post-injury confusion or headaches

Concussions: ____

Anoxia (a sustained lack of oxygen): ______________________________

Exposure to toxins: ____

Other: ____



Current Medications
Please list CURRENT medications and include medication name, dose (mg), schedule (when you take them) and date you started taking them.

Medication Name	Dose	Schedule	Date Started

Past Medications
Please list PAST medications related to your symptoms in chronological order, if possible. Please indicate if the medication was helpful or not in relieving your symptoms under column that says “Effectiveness.”

Medication Name	Dose	Date Stopped	Effectiveness

Allergies and Adverse Reactions to Medications

Allergen	Type of Adverse Reaction/Symptoms

Surgical and Hospitalization History
Please list all the major surgeries and hospitalizations you have had:

Operation/Hospitalization	Date

Imaging/Testing History

Have you had other nuclear medicine tests or procedures? ☐ Yes ☐ No
If yes, list date and type of procedure(s) ______________________________

Please fill in the information below if you have had any imaging/testing of your brain or head.

MRI Results ______________________________ Year__________

CT (“cat” scan) Results______________________________ Year__________

EEG (“electrodes” on head) Results ______________________ Year__________

Note: If an MRI or CT with abnormal findings of your brain or head was done within the last 10 years, you may be asked to provide a copy of the images. If you had an abnormal EEG, a copy of the report may be requested.

Developmental Information

Current Weight: _______lbs. Height: _______

Was there any birth trauma (i.e. umbilical cord wrapped around neck)? ☐ Yes ☐ No
If yes, please explain______________________________

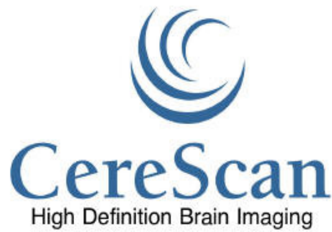
List any recurrent or severe childhood illnesses: ______________________________

Were there any delays in your language or motor development? ☐ Yes ☐ No
If yes, please explain______________________________

Were you in any special education classes at school? ☐ Yes ☐ No
If yes, which grades and classes______________________________

Trauma or Abuse History (please check any that apply):

☐ Emotional abuse ☐ Physical abuse ☐ Sexual abuse ☐ other major traumas



Alcohol and Substance Use/Abuse

Current number of alcoholic drinks per week: ______________________________

Current use of recreational drugs: ______________________________

Current use of narcotics: ______________________________

Do you have any history of alcohol or drug abuse? ☐Yes ☐No

If yes, please explain: ______________________________

Current caffeine consumption: ______________________________

Current tobacco consumption: ______________________________

Family History of all major medical or psychiatric Illness

Mother: ______________________________

Father: ______________________________

Siblings: ______________________________

Maternal Grandparents: ______________________________

Paternal Grandparents: ______________________________

Other blood relatives (specify): ______________________________

Education:

Highest level of education completed: ____________________

Degree(s) achieved: ☐ GED ☐ H.S. diploma ☐ Trade school ☐ Associate's degree

☐ Bachelor's degree ☐ Master's degree ☐ Doctoral degree

Legal History (arrests, DUI, etc.): ______________________________

Veteran History

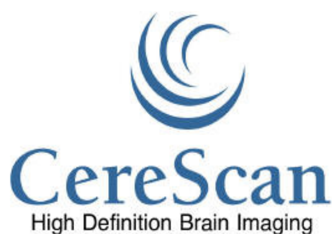
Are you currently serving in the Armed Forces? ☐ Yes ☐ No

Have you ever been deployed to a war zone? ☐ Yes ☐ No

If yes, when and where was this? ______________________________

Have you ever been in combat? ☐ Yes ☐ No

If yes, when and where was this? ______________________________



HIPAA Compliant
Authorization to Release/Obtain Patient Information

Patient Name:			**Date of Birth:**		
Obtain from/release to (circle one)**:**			**Obtain from/release to** (circle one)**:**		
			CereScan		
Name					
			866-722-4806	**866-433-3965**	
Phone	Fax		Phone	Fax	
			990 S. Logan Street		
Address					
			Denver	**CO**	**80209**
City	State	Zip			

Please check the information to be released below.

___ Report and Images	___ Appointment Information
___ Demographic Information, including Patient Billing Information	___ Information Regarding Neurological/Psychological/Psychiatric Conditions
___ Other	

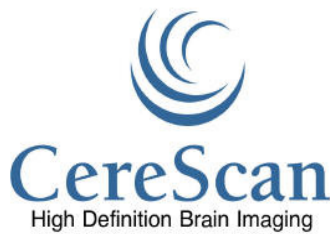
AUTHORIZATION: I certify I have signed this request voluntarily, without any form of pressure or coercion being placed upon me by anyone. I hereby release both of the above parties from any liability which may result from this exchange of information. I understand that only I may revoke this authorization at any time, except to the extent that the action has already been taken to comply with it. **This consent will automatically expire one year after the date of signing unless otherwise indicated.**

____

Date **Signature of Patient or Legal Guardian**

____

Date **Signature of Patient (if Patient is a Minor Child of At Least 14 Years Old or Older)**



Patient Instructions

A. In general, our physicians require all patients to be off *stimulant medication* (i.e. Ritalin, Adderall, Concerta, Provigil, etc.) at least four days before the first scan, and remain off of it until the second scan is completed. **It is the patient's responsibility to inform his/her primary care physician (or the doctor prescribing the stimulant medication) of the required abstinence from such stimulants, and to follow your doctor's recommendations for tapering off**. You must also follow your doctor's advice for resuming any stimulant medication that you temporarily stopped taking for this evaluation. CereScan does **NOT** recommend going off other medications. Substances which you must eliminate prior to the scans are listed below. Please have your physician or therapist call our Patient Care Department at 866-722-4806 with any questions.

B. **48 hours** prior to the first scan, **eliminate** the following:

- Caffeine, including but not limited to, coffee, tea, green tea, iced tea, chocolate, most soda pops, sports drinks, energy drinks, etc.
- Cold medications, especially those containing Sudafed or other decongestants, or nasal sprays such as Afrin
- Vitamins or supplements with ephedrine, caffeine, guarana or steroids
- Over the counter medications that have caffeine as an ingredient. Brand names include, but are not limited to, Excedrin, Midol, Anacin, No Doze, Vivarin, and Bayer Headache Relief
- Nicotine, including but not limited to, cigarettes, gum, chewing tobacco, nicotine patch, etc.
- Illicit drugs, including but not limited to, marijuana, cocaine, methamphetamine, etc.

C. **24 hours** prior to the scan, **eliminate** your intake of alcohol.

PLEASE NOTE: If you are a heavy user of alcohol, caffeine or illicit drugs, please contact your doctor now about a tapering-off plan in preparation for your brain scans.

D. If you are **ALLERGIC** to **PLASTIC** please call us immediately.

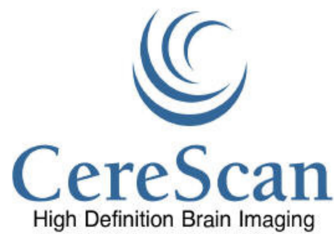
E. The key to a successful brain scan is to remain motionless while the camera is imaging your brain. You will need to remain motionless for approximately 30 minutes. If you have any concerns about being able to remain still for the duration of the scan, please contact your Patient Care Coordinator immediately. Due to the sensitivity of the radioisotope, payment will be required even if you are unable to remain still for the full scan, because of the need to reschedule that scan.

F. Please dress comfortably so that you are relaxed. Also, dress warmly since our imaging room may be chilly. Please wear a collarless, well-fitted top such as a T-shirt and sweater or other warm collarless layer. Prior to the scans, please remove any barrettes and jewelry or piercings above the neck. The technologist may ask you to wear a hairnet for the scans to allow the camera to get as close to your head as possible.

G. Prepare yourself for a fairly lengthy visit for your appointments at our clinic.

- Your scan appointments will take approximately 2.5 hours each.
- The review of your brain scan report will last about 1 hour.

H. Relax ☺ The staff at our clinic is friendly and professional, and will gladly answer any additional questions you may have when you arrive at CereScan.



Frequently Asked Questions

Are there any side effects or risks to the brain imaging study? The study does not involve a dye so allergic reactions are very rare; if one does occur it usually involves only a mild, self-limited skin reaction such as a rash. Please let the technologist know if you experience any unusual symptoms during or after the injection of the radioisotope.

Will I feel pain when the radiopharmaceutical is injected? You will only feel a small pinch from the needle as it is placed into your vein.

How is the brain scan procedure done? Prior to the scan, you will sit in a comfortable and quiet room and a small intravenous (IV) line will be started. On the day of the concentration study, you will be given a simple computer task to do. The imaging agent will be injected through your IV approximately 5 minutes into the computer task. This will create a "snapshot" of your brain activity during concentration. After a waiting period of approximately 40 minutes, the technologist will take you into the camera room. You will lie down on the padded camera table and be positioned between the 2 camera detectors, which will image your brain. The closer the camera is to your head, the better the images of your brain will be. For the "resting" study (approximately 2 days later), the process is almost the same as the first scan except, instead of doing a computer task during the injection period, you will sit quietly in a comfortable chair for about 25 minutes; the room lights will be dimmed and you will wear sound dampening headphones to minimize noise.

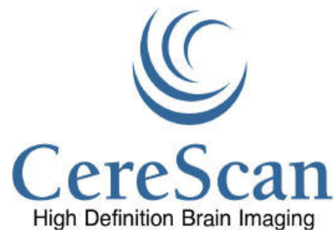
Will I be alone? No, the technologist (and a parent if applicable) will be nearby during the process.

Will the camera touch me? The camera will rotate around your head and shoulders but no part of the machinery will touch your body. You will not go through a tube. The time on the camera table is approximately 30 minutes.

Will I get a diagnosis from the brain scans? Your doctor will use the data from your functional brain scan report to help form a conclusion about your condition or assign a diagnosis. CereScan does not directly assign you the diagnosis.

Can I move during the scan? No, you cannot move during the scan. Your head and body must remain motionless (blinking eyes and swallowing are okay) for approximately 30 minutes or the scan will be compromised and unreadable by our physicians. The camera table has a soft cushion and most patients find it quite comfortable.

After I've been injected with the radioisotope, should I avoid physical contact with others? No, that is not necessary. In general, the radioisotope you are given will remain in your body for a short period of time. It is eliminated by urination, thus drinking more fluids afterwards will aid this process. If you are traveling by airplane within 24 hours following a scan, please make sure to let the technologist know. If any special precautions are necessary, the technologist will advise you. If you are nursing, you will receive and need to comply with the *Policies and Procedures for Patients who are Breast-feeding.*



Frequently Asked Questions (continued)

What should I do after the scans? You can return to any regular activities of daily living (driving, work, school, exercise, etc.). However, it will be necessary to increase your intake of fluids to aid the elimination of the radioisotope from your body. The goal is to urinate twice in the two hours following the injection. The technologist will provide discharge instructions.

When will I get the results of my brain scan? When your scans are completed, a nuclear medicine physician will review your images, prepare a report and discuss the results with a CereScan clinician. A final appointment will occur when the clinician will review your brain scan report and images with you. The report review can be done in person at our clinic, via web conference or by conference call. You are welcome to include a family member, your therapist, treating physician, or friend in this review session. You will be given a copy of your scan report and images. A copy will also be sent to your referring physician.

What are the other types of functional brain studies? It is our opinion that single photon emission computed tomography (SPECT) is the most clinically useful study of brain function. There are other studies such as electroencephalogram (EEG), Positron Emission Tomography (PET) studies and functional MRI (fMRI). PET studies and fMRI are considerably more costly and time consuming than SPECT. The EEG, in our opinion, does not provide enough information about the deep structures of the brain to be as helpful as SPECT studies.

Is the use of brain SPECT imaging accepted in the medical community?
The *American College of Radiology (ACR)* and the *Society of Nuclear Medicine (SNM)* endorse the use of single photon emission computed tomography in the evaluation of cerebrovascular disease and stroke, evaluation of dementia and suspected Alzheimer’s disease, pre-surgical localization of epileptic foci, diagnostic evaluation of encephalitis and evaluation of suspected brain trauma. Research has also demonstrated regional blood flow patterns associated with other neurological disorders and with exposure to neurotoxins, hypoxia and substances of abuse. While functional brain imaging is not considered an exact science for diagnosing psychiatric conditions, there are hundreds of peer-reviewed, published research studies utilizing SPECT for the evaluation of these conditions. If interested, please contact our clinical staff for additional information and resources.

CereScan
High Definition Brain Imaging

DRIVING DIRECTIONS

From the South:
Take I-25 northbound to the Downing Street, exit 206. When you exit the highway, bear to the left under the sign for Washington St. and Emerson St. Stay on this exit road until you reach the T-stop at Logan St. Turn right (north) on Logan, and we are located 1 block, on the right side of the street at the corner of Logan and Tennessee. The parking lot is on the north side of the building

From the North:
Take I-25 southbound to the Broadway, exit 207B. Go right (south) on Broadway, turn left (east) on Mississippi and left (north) on Logan. Cross over the interstate go 2 more blocks. Our office is on the right side of the street at the corner of Tennessee and Logan. The parking lot is on the north side of the building

From the central Denver area:
Take Speer Blvd to Washington Street. Go south on Washington St., turn right (west) on Alameda, and then turn left (south) on Logan. We are located at 990 S. Logan on the east side of the street, two blocks before the I-25 overpass.