

# CT Brain Scan Radiology Report

Patient Name: \_\_\_\_\_ ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Examination Date: \_\_\_\_\_ Study No: \_\_\_\_\_

Clinical Details:

\_\_\_\_\_

Technique:

\_\_\_\_\_

Findings:

\_\_\_\_\_

Impression:

\_\_\_\_\_

Recommendations:

\_\_\_\_\_

Radiologist: \_\_\_\_\_

Signature: \_\_\_\_\_

Report Date: \_\_\_\_\_