Association of Boxing Commissions and Combative Sports

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:** _____

***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 <u>NOT</u> 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**

Forms Courtesy of :
Dr. Michael Schwartz
Co-Chairman – Medical Advisory Committee