UPMC LIFE CHANGING MEDICINE

Department of Neurological Surgery

# Cover Sheet/Checklist

## Patient/Contact Information

Patient's Name _____

Diagnosis _____

Signs and Symptoms _____

**Patient's Address:**

Street _____

City _____

State _____

Zip Code _____

Country _____

Patient's Phone _____

Contact Person other than Patient _____

Contact Person's Phone _____

## Please Enclose the Following Items

- ☐ Completed Cover Sheet/Checklist
- ☐ Medical Records
- ☐ Films, MRIs, etc.
- ☐ Written clinical reports for films

## Please Send Your Package to:

**Attn: Film Review/Conference**
**Department of Neurological Surgery**
**Minimally Invasive endoNeurosurgery Center**
**UPMC Presbyterian, Suite B-400**
**200 Lothrop St.**
**Pittsburgh, PA 15213**

## For Administrative Use

Date Received _____ Date Reviewed _____

Reviewed by _____

Date Replied to patient _____

Plan _____

Films/Records returned to _____ Date _____