FRIEDEL CLINIC

Patient Information:

Patient's Name:_____ Gender_____ Date of Birth_____

If minor, Guardian Name: _____Phone: _____

Referral Source:

Referral Name:_____ Credentials:_____

Agency:_____ Phone:_____

Email:_____

Reason for Referral

Diagnosis or reason for the referral:

_____

_____

Your goal for the evaluation:

_____

Central question you would like answered:

_____

Services Requested:

Please check all requested

- ☐ Brain Health Evaluation
- ☐ Neurofeedback
- ☐ Hyperbaric Oxygen Therapy
- ☐ qEEG Mapping
- ☐ Sleep Study
- ☐ Neurotransmitter Lab Test

Along with this referral, Friedel Clinic requests that you please submit any and all documents supporting the need for referral.