BrainStim CENTERS

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PATIENT REFERRAL

Please fax to 818-475-1433 or email to info@brainstimcenters.com

Referring Physician Name: _____

Referring Physician Phone Number: _____

Referring Physician E-mail Address: _____

Referring Physician Specialty: _____

Patient Name: _____ Phone Number:_____

Patient Primary Insurance & Subscriber ID: _____

Patient Secondary Insurance & Subscriber ID: _____

Comments:

_____

_____

_____

Diagnosis (*check all that apply*):

- ☐ Depression
- ☐ Tinnitus
- ☐ PTSD
- ☐ Addiction
- ☐ Chronic Pain
- ☐ Anxiety
- ☐ OCD