BrainStim CENTERS

28212 Kelly Johnson Pkwy., Suite# 215, Valencia, CA 91355
16260 Ventura Blvd., Suite #700, Encino, CA 91436
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PATIENT REFERRAL FORM

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 (List current medications and indicate if the patient has history of seizures or stimulator implants):

_____

_____

DIAGNOSIS (*check all that apply*):

- ☐ Depression
- ☐ Addiction
- ☐ OCD
- ☐ Autism
- ☐ Tinnitus
- ☐ Chronic Pain
- ☐ ADD / ADHD
- ☐ Post-Concussive Syndrome
- ☐ PTSD
- ☐ Anxiety
- ☐ Sleep Disorder

PATIENT AUTHORIZATION:

I authorize my physician to release any records acquired during the course of my treatment to referring physicians, insurance companies, hospitals or surgery centers. I authorize the release of all information necessary to transmit and process claims electronically and/or through any other reasonable and customary means under HIPPA compliance.

PRINT PATIENT NAME: _____ **PATIENT SIGNATURE:** _____ **DATE:** _____