



CALIFORNIA
4482 Barranca Pkwy Suite 240
Irvine, CA 92604

ARIZONA
4045 E Union Hills Dr. Suite 116
Phoenix, AZ 85050

TEXAS
11655 Independence Pkwy Ste
200
Frisco, TX 75035

FLORIDA
2340 Dairy Rd, Suite 104
Melbourne, FL 32904

REFERRAL FORM

Patient Name: _____ Date of Birth: _____

Parent/Care Giver's Name: _____ Relationship: _____

Phone Number: _____ Email: _____

Medications (please list all) _____

Indication for study: _____

- | | |
|--|---|
| <input type="checkbox"/> R41.82 Altered mental status, unspec. | <input type="checkbox"/> G40.A09 Absence Epileptic Syndrome |
| <input type="checkbox"/> R25.9 Abnormal involuntary movements, unspec. | <input type="checkbox"/> G40.802 Other epilepsy, not intractable without status |
| <input type="checkbox"/> R06.81 Apnea, not elsewhere classified | <input type="checkbox"/> G40.822 Epileptic Spasms, not intractable without status |
| <input type="checkbox"/> G04.81 Autoimmune or Other Encephalitis | <input type="checkbox"/> G40.89 Other Seizures |
| <input type="checkbox"/> G40.101 Focal or Partial Symptomatic Epilepsy | <input type="checkbox"/> R.56.9 Unspecified Convulsion |

Diagnosis Codes: _____

Check any or all that apply:

- Epilepsy Dx Recent Seizure Head Injury Headaches
- Developmental Delays Autism Spectrum Staring Spells

CLINICAL INFORMATION

Length of Study: 24 hour 48 hour. 72 hour

** All EEG Studies will be done with continuous video recording, unless otherwise noted.*

Ordering Physician: _____ Signature: _____



BRAIN SCIENCE TECHNOLOGIES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work/Cell Phone: _____

The above-named patient authorizes the release of their medical records to:

Brain Science Technologies

EEG TO GO



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ATTN: Billing Department

Phone: (678)470-7515

Fax: (949)333-5086

Email: monarchbillingsolutions@gmail.com

Please release medical records, including history and physical, presenting symptoms and chart notes pertaining to the necessity of the EEG. Please include any former EEG reports if applicable.

I understand that by signing this form, I am authorizing the use or disclosure of protected health information as indicate above.

I have read the above foregoing Authorization of Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____

Signature of Patient/Representative

Date

Print Name

Relationship to Patient