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
- ☐ EMDR

Along with this referral, Friedel Clinic requests that you please submit any and all documents supporting the need for treatment. These can include but are not limited to All medical records, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient, and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurses' notes, social worker records, clinical records, treatment plans, admission records, discharge summaries, request for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, all laboratory, histology, anthology, records, and specimens; radiology records and films including CT, PET, SPECT, MRI, fMRI, MRA, EEG, qEEG scans. Videos/CDs/reports and all pharmacy/prescription records, including NDC numbers and drug information.

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