BOULDER
Natural Health

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QEEG BRAIN MAPPING REFERRAL

Complete on screen or by hand, then fax it or send it with your client.

FAX COMPLETED FORM TO
720.899.3817

1 CLIENT INFORMATION

Client name _____

Date of birth _____

Client phone _____

Client email _____

Parent / guardian name (if under 18) _____

2 REFERRING PROVIDER

Provider name & credentials _____

Practice name _____

Phone _____

Fax _____

Email _____

3 REASON FOR REFERRAL

Areas of concern (check all that apply)

- ☐ Attention & focus
- ☐ Mood
- ☐ Anxiety & stress
- ☐ Sleep
- ☐ Learning or behavior
- ☐ Hormonal / life transition
- ☐ Brain fog / cognitive health
- ☐ Performance & wellness
- ☐ Other: _____

Relevant diagnoses *(if any)*

Current symptoms & brief history

Current medications & supplements

What would you like the QEEG to help clarify? *(optional)*

4 REPORT & OPTIONS

Send results to me by: ☐ Fax ☐ Secure email

Optional add-ons ($60 each, paid by client):

- ☐ Medication Research Summary
- ☐ Neurofeedback Protocols
- ☐ Photobiomodulation Protocols

☐ I have reviewed the QEEG preparation instructions with my client.

We obtain the client's signed release at their appointment before sharing results with you.

Provider signature _____

Date _____

QEEG is intended for the visualization and review of physiological data as an aid to the clinician's own evaluation. Final interpretation, diagnosis, and treatment decisions remain the responsibility of the treating provider.

Your client stays your client.

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