



EEG Laboratory Referral Form

Fax to: 720-274-0064

Patient Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Insurance Carrier: _____

Referring Provider: _____ Phone: _____ Fax: _____

I would like a phone call with the results at the conclusion of the study in addition to the faxed report.

No phone call is necessary, the faxed report is sufficient.

Specific Provider Requested:

- | | | |
|---|--|--|
| <input type="checkbox"/> Kirsten Bracht, MD | <input type="checkbox"/> Aaron Haug, MD | <input type="checkbox"/> Marc Wasserman, MD |
| <input type="checkbox"/> Richard Clemmons, MD | <input type="checkbox"/> Kimberly Horiuchi, MD | <input type="checkbox"/> Lynn Zhang, MD |
| <input type="checkbox"/> Beverly Gilder, MD | <input type="checkbox"/> Chuck Livsey, MD, PhD | <input type="checkbox"/> First Available / No Preference |

Symptom or Diagnosis: _____

Prior History of Seizures: Yes No

Seizure Type if known: _____

Medication List: _____

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