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:

☐ **Kirsten Bracht, MD**	☐ **Aaron Haug, MD**	☐ **Marc Wasserman, MD**
☐ **Richard Clemmons, MD**	☐ **Kimberly Horiuchi, MD**	☐ **Lynn Zhang, MD**
☐ **Beverly Gilder, MD**	☐ **Chuck Livsey, MD, PhD**	☐ **First Available / No Preference**

Symptom or Diagnosis: _____

_____

Prior History of Seizures: ☐ Yes ☐ No

Seizure Type if known: _____

Medication List: _____

_____

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