BTC
BRAIN TREATMENT CENTER

Referral Request Form*

Thank you for choosing the Brain Treatment Center. We look forward to partnering in your patient's care.

Date: _____

☐ Newport – P: 949-851-3086 F: 949-398-8072

☐ San Diego – P: 619-255-2101 F: 619-255-2101

☐ Seattle - P: 206-430-7851 F: 206-430-7855

☐ Los Angeles – P: 424-372-3150 F: 424-372-3169

Referring Provider:

Referring MD: _____

Phone: _____ Fax: _____

Address: _____ City: _____ Zip: _____

This form completed by: _____ Phone: _____

Patient information (Please provide copy of patient demographics/face sheet):

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Gender: Male/Female Phone: _____

Address: _____

City/State/Zip: _____

Interpreter: Yes No Language: _____

Reason for Referral:

☐ ADD/ADHD ☐ Chemo Brain ☐ Stroke

☐ Autism ☐ Depression ☐ Optimization

☐ PTSD ☐ TBI ☐ Other: _____

Documentation Required (Please fax with this form):

✦ **Recent/relevant typed clinical notes/test results** i.e. History & physical, MRI/CT/X-ray

**To successfully refer a patient for MeRT℠ treatment, please make sure that you have read and reviewed the contraindications list found on our website at www.braintreatmentcenter.com/faq#absolute*