AMEN CLINICS REFERRAL FORM

Date:

Patient Information:

Patient's Name: Gender: ☐ Male ☐ Female

Age: If minor, guardian name: Phone:

Referral Source Information:

Referral Source: Credentials: Are you a BHCCC? ☐ Yes ☐ No

Address:

Phone: Fax: Email:

Diagnosis or reason for referral:

Procedure Requested:

- ☐ Two Scan Evaluation–Concentration and Resting SPECT scans, detailed history, clinical evaluation, and report
- ☐ Single Scan Evaluation (Concentration or Resting)
- ☐ Scan Only (Must have pre-approval)
  - ☐ Concentration & Resting SPECT Scans ☐ Single Concentration SPECT Scan
- ☐ Re-SPECT Concentration SPECT Scan and Physician Evaluation and report
- ☐ Scan Only Re-SPECT ☐ Follow up Concentration SPECT Scan ☐ Follow up Baseline SPECT Scan
- ☐ Sedation Scan Evaluation
- ☐ Medication Evaluation
- ☐ Other

Please advise your patient on whether or not to stay on their medications for their scan.

Patient's Medications	Status for Scan
	☐ On ☐ Off
	☐ On ☐ Off
	☐ On ☐ Off
	☐ On ☐ Off

*Amen Clinics does not recommend stopping medication unless under the guided supervision of a physician.

Additional Services * (available at select locations):

- ☐ **Neurofeedback** ☐ **Hyperbaric Oxygen Therapy (HBOT)** ☐ **qEEG (Quantitative electroencephalography)**
- ☐ **Individual/Family Counseling** ☐ **Transcranial Magnetic Stimulation Therapy (TMS)** ☐ **Nutrition Services**
- ☐ **AmenLink** ☐ **Other**

AMEN CLINICS CONTACTS

ATLANTA | P: 678-367-2810 | F: 678-805-8125
CHICAGO | P: 224-804-9220 | F: 224-241-3154
NEW YORK | P: 646-736-3110 | F: 949-236-8691
NORTHWEST | P: 425-455-7500 | F: 425-454-7845
NORTHERN CALIFORNIA | P: 650-416-7830 | F: 650-871-8874
ORANGE COUNTY, CA | P: 949-266-3700 | F: 949-266-3750
WASHINGTON, D.C. | P: 703-880-4000 | F: 703-860-5760
LOS ANGELES | P: 818-479-4400 | F: 818-305-3779

CONSENT FOR MEDICAL RELEASE OF INFORMATION

Patient's Name (Please Print):

I authorize Amen Clinics, Inc. to furnish records and medical information, including but not limited to information about general medical care, outpatient treatment with a psychotherapist, HIV/AIDS test results, and substance abuse/chemical dependency treatment of federal or state assisted programs, concerning the above-named patient to the following listed persons. **By selecting Information Release, you are authorizing us to release all information to those listed below as well as through our HIPAA secured Web Portal and requesting we send them a copy of your final report**. If the professional listed referred you, please select the Referring Professional box below so we can thank them.

☐ Self Only

Parent, Legal Guardian, or Spouse

Name: Phone/Fax:

Mailing Address:

☐ Guarantor ☐ Emergency Contact ☐ Information Release

Doctor, therapist or other (Please include specialty/credentials)

Name:

Mailing Address:

Phone/Fax: Email :

☐ Information Release; Send copy of Final Evaluation Report ☐ yes ☐ no; ☐ Referring Professional

Doctor, therapist or other (Please include specialty/credentials)

Name:

Mailing Address:

Phone/Fax: Email :

☐ Information Release; Send copy of Final Evaluation Report ☐ yes ☐ no; ☐ Referring Professional

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