Nashville NeuroCare Therapy
nashvilleneurocare.com

Cool Springs Office
2001 Mallory Lane
Suite 304
Franklin, TN 37067

Referral for Neurofeedback

To: Cadey Phipps, LMFT
Fax: (615)472-9479
Phone: (615) 465-4875

Date: _____
From: _____
Phone: _____
Fax: _____

I would like to refer Mr./Ms. _____ to you for an evaluation to consider Neurofeedback.

☐ Patient is under age 18. Please list parent(s) name(s) and contact(s):

_____

His/her contact information is as follows (**please circle preferred phone**):

Home: _____ **Cell:** _____

☐ *Patient* expecting your call ☐ *Parent* expecting your call OK to leave a message? ☐ Yes ☐ No

☐ Attached is a copy of patient's insurance card (front and back)

Patient's Primary Diagnosis: _____

Secondary Diagnosis: _____

Background information/reason for considering Neurofeedback:

_____

_____

_____

_____