



NEURON CONNECT
 qEEG BRAIN MAPPING &
 NEUROFEEDBACK THERAPY

NEURON CONNECT

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 PHOENIX - MESA - TEMPE - SCOTTSDALE - TUCSON

Medical Referral and Order Form

Date: _____

Patient Name: _____ DOB: ____/____/____

Patient Phone: _____ Patient Email: _____

Diagnosis/Current Symptoms/History: _____

Physician Signature: _____ Phone: _____ Fax: _____

Print Physician Name: _____ Email: _____

Payment Method INS: Aetna, BCBS, Cigna, Humana, Medicare, Optum, United Attorney Lien Cash ESA

Reason for Service (check all that apply)

qEEG Brain Map, as diagnostic aide Neurofeedback Therapy Neurology Neuro. Psychiatry

Symptoms / Current Concerns (check all that apply)

- | | | | |
|-------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Developmental Concerns | <input type="checkbox"/> Learning Difficulties | <input type="checkbox"/> Sound Sensitivity |
| <input type="checkbox"/> Attention / Focus Difficulty | <input type="checkbox"/> Dizziness / Vertigo | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Sports Concussion History |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Emotional Dysregulation | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> TBI / Head Injury History |
| <input type="checkbox"/> Behavioral Concerns | <input type="checkbox"/> Executive Function Difficulty | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Test Anxiety |
| <input type="checkbox"/> Brain Fog | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck Pain / Whiplash | <input type="checkbox"/> Tinnitus / Ringing in Ears |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Nightmares / Sleep Disturbance | <input type="checkbox"/> Vision Changes |
| <input type="checkbox"/> Cognitive Decline | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Poor Sleep / Insomnia | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Concentration Difficulty | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> PTSD / Trauma History | Other Symptoms / History: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability / Anger | <input type="checkbox"/> Sensory Sensitivity | _____ |

ICD-10 Diagnostic Codes (check all that apply)

- | | | |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> F02.818 – Dementia in Other Diseases with Behavioral Disturbance | <input type="checkbox"/> F84.0 – Autism Spectrum Disorder (ASD) | <input type="checkbox"/> H81.10 – Vertigo |
| <input type="checkbox"/> F03.90 – Dementia, Unspecified | <input type="checkbox"/> F84.9 – Pervasive Developmental Disorder, Unspecified | <input type="checkbox"/> H93.19 – Tinnitus |
| <input type="checkbox"/> F07.81 – Post-Concussion Syndrome | <input type="checkbox"/> F90.0 – ADHD – Inattentive Type | <input type="checkbox"/> M54.2 – Cervicalgia / Neck Pain |
| <input type="checkbox"/> F10.10 – Alcohol Use Disorder | <input type="checkbox"/> F90.2 – ADHD – Combined Type | <input type="checkbox"/> M79.7 – Fibromyalgia |
| <input type="checkbox"/> F11.10 – Opioid Use Disorder | <input type="checkbox"/> F90.9 – ADHD / Attention Deficit Disorder | <input type="checkbox"/> R26.89 – Balance Problems |
| <input type="checkbox"/> F19.10 – Substance Use Disorder | <input type="checkbox"/> F98.9 – Emotional/Behavioral Dysregulation | <input type="checkbox"/> R41.3 – Memory Loss |
| <input type="checkbox"/> F31.9 – Bipolar Disorder | <input type="checkbox"/> G04.81 – Autoimmune Encephalitis | <input type="checkbox"/> R41.81 – Cognitive Decline |
| <input type="checkbox"/> F32.A – Depression | <input type="checkbox"/> G31.84 – Mild Cognitive Impairment (MCI) | <input type="checkbox"/> R41.840 – Attention / Concentration Deficit |
| <input type="checkbox"/> F33.9 – Major Depressive Disorder / Recurrent Depression | <input type="checkbox"/> G40.909 – Seizure Disorder / Epilepsy | <input type="checkbox"/> R41.844 – Executive Function Deficit |
| <input type="checkbox"/> F39 – Mood Disorder | <input type="checkbox"/> G43.909 – Migraine | <input type="checkbox"/> R41.89 – Brain Fog / Cognitive Changes |
| <input type="checkbox"/> F41.0 – Panic Disorder | <input type="checkbox"/> G44.329 – Chronic Post-Traumatic Headache | <input type="checkbox"/> R42 – Dizziness |
| <input type="checkbox"/> F41.1 – Generalized Anxiety Disorder | <input type="checkbox"/> G47.00 – Insomnia | <input type="checkbox"/> R45.4 – Irritability / Anger |
| <input type="checkbox"/> F41.9 – Anxiety Disorder | <input type="checkbox"/> G47.33 – Obstructive Sleep Apnea | <input type="checkbox"/> R45.87 – Impulsivity |
| <input type="checkbox"/> F42.9 – Obsessive Compulsive Disorder (OCD) | <input type="checkbox"/> G47.9 – Sleep Disorder | <input type="checkbox"/> R51.9 – Headache |
| <input type="checkbox"/> F43.10 – PTSD / Trauma | <input type="checkbox"/> G89.29 – Chronic Pain | <input type="checkbox"/> R53.82 – Chronic Fatigue |
| <input type="checkbox"/> F43.20 – Adjustment Disorder | <input type="checkbox"/> G93.32 – Chronic Fatigue Syndrome / Post-Viral Fatigue | <input type="checkbox"/> R53.83 – Fatigue |
| <input type="checkbox"/> F45.42 – Chronic Pain Syndrome | <input type="checkbox"/> G93.40 – Encephalopathy, Unspecified | <input type="checkbox"/> S06.0X0A – Concussion W/out Loss of Conscio. |
| <input type="checkbox"/> F50.9 – Eating Disorder | <input type="checkbox"/> G93.49 – Other Encephalopathy | <input type="checkbox"/> S06.9XAS – Traumatic Brain Injury Sequela |
| | | <input type="checkbox"/> S09.90XA – Closed Head Injury |
| | | <input type="checkbox"/> U09.9 – Long COVID / Post-COVID Condition |
| | | <input type="checkbox"/> Other: _____ |

Please email or fax this completed order for us to obtain prior authorization. Thank you.

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