

TO: Building Biology WA

Unit 1

22 Grand Boulevard

JOONDALUP WA 6027

Name of Referring Practitioner:

Address of Referring Practitioner:

Phone No. of Referring Practitioner:

Email Address of Referring Practitioner:

Patient Full Name:

Patient Address:

Patient Phone No:

**Environmental Factors to be Tested** (please check all that apply):

* + Electropollution
	+ Mould & Biotoxins
	+ Allergens & House Dust Mite
	+ Chemical & Toxic Exposures
	+ Water Contaminants
	+ Indoor Air Quality
	+ Other:

**Do you suspect your Patient suffers from Heavy Metal Toxicity?** (please check 1 only)

* + Yes
	+ No
	+ Maybe

**Has your Patient been tested for Heavy Metal Toxicity?** (please check 1 only)

* + Yes
	+ No

**Do you suspect your Patient suffers from Chemical Sensitivities?** (please check 1 only)

* + Yes
	+ No
	+ Maybe

**Has your Patient been tested for Chemical Sensitivities?** (please check 1 only)

* + Yes
	+ No

**Does your Patient suffer from any known Allergies?** (please check 1 only)

* + Yes
	+ No
	+ Maybe

**Has your Patient been tested for any Allergies?** (please check 1 only)

* + Yes
	+ No

**Do you suspect your Patient suffers from Electrohypersensitivity?** (please check 1 only)

* + Yes
	+ No
	+ Maybe

**Do you suspect your Patient suffers from a Sleep Issue/Disorder?** (please check 1 only)

* + Yes
	+ No
	+ Maybe

**If you answered Yes to any of the above questions, please provide further details regarding your suspicions & results of any tests that have been carried out:**

**Would you like to receive an electronic copy of your Patient’s summary of findings?** (please check 1 only)

* + Yes
	+ No

**If yes, what email address would you like the findings sent to?** (please check 1 only)

* + Same email address as (for Referring Practitioner) above
	+ Other:

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