Alaska NEURO
Associates, LLC
Comprehensive Evaluations. Relevant Recommendations.

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Patient Referral for ImPACT Post-Concussion Testing

Referred To: **Russell Cherry, Psy.D. and/or Heather Macomber, Ph.D.**

Patient Name ______________________________________DOB_____________M____ F____

Mailing Address _____________________________City ___________ State ____ Zip ________

Phone Number Home_________________ Work _________________ Cell _________________

Parent/Guardian (if applicable):____

Referring Physician:____

School/Organization:_________________________________ Date of Injury:________________

Sport:____________________________ Event/class/position:_____________________________

Previous head injuries (dates/description): ____

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Description of Current Injury:____

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Current Symptoms (check yes):

___ Headache	___ Trouble falling asleep	___ Irritability	___ Difficulty concentrating
___ Nausea	___ Sleeping too much	___ Sadness	___ Memory problems
___ Vomiting	___ Sleeping too little	___ Emotional	___ Visual problems
___ Balance Problems	___ Sensitivity to light	___ Numbness or tingling	
___ Dizziness	___ Drowsiness	___ Feeling too slow	
___ Fatigue	___ Sensitivity to noise	___ Mentally “foggy”	