

NEUROPSYCHOLOGY REFERRAL FORM

Please answer all questions and attach: Recent progress notes; Demographic information; Insurance information

NOTE: If there is more that you would like to tell us about this patient, please attach to the referral.

Patient Name: _____ Referring Provider: _____

Patient's DOB: _____ Gender: M / F Today's Date: _____

Person to contact for scheduling: _____ Relationship to Patient: _____

Phone Number for Scheduling: _____ Patient's Phone number: _____

Patient or scheduler's Email Address: _____

List rule-out medical diagnoses (Note: ADD/ADHD alone is not acceptable for any insurance including Medicaid/Medicare):

<u>Medical Conditions:</u>	<u>Psychiatric Conditions:</u>		
Head Trauma / TBI	ADHD	Psychosis	Somatoform
Dementia	Learning Disorder	Depression	Bipolar
Delirium	Conduct/Behavioral	Personality	PTSD
Autism Spectrum	Mental Retardation	RAD	Anxiety

Working Diagnosis – ICD-10(Must be filled out for medical necessity) : _____

1. Suspected brain damage due to any of the following:

Seizure	LOC	CHI	FASD
Toxin Exposure	Anoxia/Hypoxia	Overdose	Inhalants
Polysubstance Abuse	CVA-Infarct-TIA	Concussion	

2. Type of problem/the patient is reporting problems with: Circle all that apply

Memory	Comprehension	Problem solving	Learning
Multitasking	Expressive Language	Planning	Spatial Orientation
Judgment	Attention/Concentration	Interpersonal	Processing Speed

3. When did the problem first start? (Month/Year) _____ Since then did it: (Circle) Worsen/Same/Improve

4. What specific question would you like this evaluation to answer? (Do Not Leave Blank) _____

5. Will the patient require a caregiver/significant other to act as a reliable historian? Yes / No

6. Workman's Compensation, Legal or open court case? Y / N

7. Is the patient NONVERBAL? Y / N

8. In what areas has the problem changed the patient's life? Circle all that apply

Living independently	Taking medications	Reading	Shopping
Cooking/Eating	Keeping appointments	Speech	Finances
Dressing/Hygiene	Employment	Following directions	Relationships
Driving a car/using a bus	Writing	Judgment	Decision-making

9. Does the patient have problems with any of the following? Circle all that apply

Seeing	Hearing	Speaking	Using hands
Sitting > 30 minutes	Fatigue/Pain	Effort	

10. Are there other conditions that may make the patient's cognitive problems worse? Circle all that apply

Depression	Malingering	Psychotic Disorder	Anxiety
Alcohol/Drug Abuse	Chronic Pain	Sexual/Physical Abuse	Sleep Disorder
Delirium	Antisocial	Personality Disorder	Diabetes/Medical Condition

11. What current stressors are in the patient's life? Circle all that apply

Death of family	Domestic Violence	Employment	Finances
Parenting	Poor Social Support	Housing/Homeless	School
Divorce	Sexual Abuse/Trauma	Transportation	Legal/Criminal Charges