CHILD NEUROPSYCHOLOGICAL CONSULTATION: PROVIDER REFERRAL

Referring Clinicians: In order to improve our clinical services and reduce wait times for patients, we have recently updated our referral process. Please read the following information in order to determine whether neuropsychological services are medically necessary for your patient. Failure to read this information may result in a delay in scheduling your patient or in a referral that is not accepted. All referrals are reviewed by a neuropsychologist to determine medical necessity.

- Is this referral for identifying a reading (i.e., dyslexia), math, or writing learning disability only? If there are additional cognitive or behavioral concerns related to this disability, the referral will be considered. Please determine in advance if the child’s school is already in the process of testing for a learning disability.

- If the patient is already diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD) and continues to demonstrate behavioral difficulties, please check that the child is receiving adequate treatment for their diagnosis (e.g. medication or behavior management). If not, please refer child to a psychiatrist and/or therapist for such services prior to referral for a neuropsychological evaluation.

- Is this a referral for psychiatric (e.g. depression) or behavioral difficulties (e.g. oppositional-defiant behavior)? If there are cognitive concerns related to these conditions, we will consider this referral. Otherwise, please refer the child for psychotherapy services and/or child psychiatry services prior to referral for a neuropsychological evaluation.

- Has this child previously been evaluated at our facility? If so, was a neuropsychological re-evaluation recommended? If not, a re-evaluation is warranted only if there has been a decline in the child’s neurocognitive functioning or a change to the child’s medical history.
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PATIENT DEMOGRAPHIC INFORMATION:
Name: ______________________________________ Date of Birth: _______________________
SS #: (needed for insurance purposes) ____________________________ Age: ____________________
Address: ___________________________________ Home Telephone #: _______________________
_________________________________________ Cell/Work Telephone #: ____________________

*PATIENT’S PRIMARY LANGUAGE ____________________ Need Interpreter? ____________________

EMERGENCY CONTACT: (If patient is minor child, please give parent/guardian information)
Name/Relationship: ___________________________________ Telephone #: ____________________

INSURANCE: Following information is not necessary if you provide copy of patient’s current insurance card (front and back)
Policy Holder Name: ___________________________ Date of Birth __________________________
Insurance Co. Name: ___________________________ Insurance Phone# __________________________
Address: ____________________________________
ID# ___________________________ Group# __________________________

REFERRING PROVIDER:
Name: _______________________________________ Telephone #: __________________________
Mailing Address: _____________________________________ FAX #: __________________________

THE FOLLOWING QUESTIONS MUST BE COMPLETED (“REFER TO CLINIC NOTES” IS NOT SUFFICIENT)

What known/suspected medical or neurodevelopmental condition is contributing to the patient’s cognitive and functional impairments? (For example: epilepsy, ADHD, recent TBI)
________________________________________________________________________________________

What is your referral question(s) – i.e. What do you hope a neuropsychological evaluation will help answer? (for example, diagnostic clarification and identification of cognitive deficits associated with this medical condition to help guide treatment?)
________________________________________________________________________________________

Is there a question of an Autism diagnosis? __________________________________________
Has the patient already been diagnosed with Autism? Yes / No (please circle one)

*Please fax any pertinent medical records, neuroimaging reports or past neuropsychological evaluations as well.

PROVIDER SIGNATURE (Required for Insurance) ____________________________________________