THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

Place UNMH patient id label here.

Center for Neuropsychological Services•915 Vassar Dr. NE Suite 170 Albuquerque, NM•Phone (505) 272-8833•Fax (505) 272-8316
Mailing Address: Center for Neuropsychological Services •Department of Psychiatry•
MSC 09 5030•1 University of New Mexico•Albuquerque, NM 87131-0001

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 it 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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CHILD **NEUROPSYCHOLOGICAL CONSULTATION: PROVIDER REFERRAL**

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)_____