ADULT NEUROPSYCHOLOGICAL CONSULTATION: PROVIDER REFERRAL

Referring Clinicians: Please read the following information in order to determine whether neuropsychological services are medically necessary for your patient. The following information is provided as a guideline for completing referrals. Please read carefully, as referrals may be delayed or denied if these guidelines are not followed. Every referral is reviewed by a staff neuropsychologist.

- Please be aware that the Center for Neuropsychological Services (CNS) is NOT able to accept referrals for patients without cognitive concerns or changes in functioning - for example, patients who only have behavioral difficulties or chronic psychiatric conditions. Please refer these patients for psychiatric evaluation or treatment instead.

- Please note that CNS does NOT provide psychiatric or psychological treatment services, such as psychotropic medication changes, pain management, or psychotherapy services.

- Is this a referral for a patient with a known psychiatric condition who is not yet psychiatrically stable (for example, a patient with ongoing bipolar disorder or PTSD)? Please refer the patient for further psychiatric evaluation or treatment first prior to referral for neuropsychological evaluation.

- Is this a referral related to traumatic brain injury (TBI) with ongoing cognitive and/or behavioral difficulties?
  - If mild TBI/concussion occurred > 1 year ago OR if moderate/severe TBI occurred >5 years ago without current declines or changes in cognitive functioning: Please refer the patient for psychiatric evaluation and/or treatment first prior to referral for neuropsychological evaluation.

- Please be aware that CNS is NOT able to provide neuropsychological evaluations to assess solely for the following disorders/conditions in adults:
  - Attention Deficit/Hyperactivity Disorder
  - Intellectual Disability
  - Learning Disability
  - Autism Spectrum Disorder
  - Spinal cord stimulator or bariatric surgery candidacy
  - Diagnostic clarification of psychiatric conditions (e.g., personality disorder, PTSD)
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PATIENT DEMOGRAPHIC INFORMATION:
Name: ___________________________________________ Date of Birth: ________________________
SS #: (required for insurance purposes) _____________________________ Age: ____________________
Address: ___________________________________________ Home Telephone #: ____________________
_________________________________________________________ Cell/Work Telephone #: ___________

*PATIENT’S PRIMARY LANGUAGE ____________________________ Need Interpreter? _______________________

EMERGENCY CONTACT:
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: ___________________________________________ Credentials: ________________________
Mailing Address: _____________________________ Telephone #: __________________________
FAX #: ______________________________________

THE FOLLOWING QUESTIONS MUST BE COMPLETED ("REFER TO CLINIC NOTES" IS NOT SUFFICIENT AND WILL RESULT IN REFERRAL DENIAL)

What known or suspected medical condition (required for insurance reimbursement) is contributing to the patient’s cognitive and functional impairments? (for example, dementia, epilepsy, recent traumatic brain injury/TBI)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What is your referral question(s) – i.e. What do you hope a neuropsychological evaluation will help answer? (for example, Does the patient have dementia? What are the patient’s cognitive strengths/weaknesses post stroke or recent TBI?)

________________________________________________________________________________________

________________________________________________________________________________________

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

PROVIDER SIGNATURE (Required for Insurance) ________________________________________________