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.

1) 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 psychiatric symptoms. Please refer these patients for psychiatric evaluation or treatment instead or at least initially prior to referral for neuropsychological evaluation.

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

3) 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.

4) Is this a referral related to traumatic brain injury (TBI) with ongoing cognitive and/or behavioral difficulties? If so, please provide medical records documenting the severity of the TBI (e.g., neuroimaging, neurological exam, hospital records) and/or details regarding the TBI characteristics [e.g., length of loss of consciousness and/or post-traumatic amnesia, Glasgow Coma Scale (GCS)].

5) Please be aware that CNS is NOT able to provide neuropsychological evaluations to assess solely for the following disorders/conditions in adults:
   a. Attention Deficit/Hyperactivity Disorder
   b. Intellectual Disability
   c. Learning Disability
   d. Autism Spectrum Disorder
   e. Spinal cord stimulator or bariatric surgery candidacy
   f. Diagnostic clarification of psychiatric conditions (e.g., personality disorder, PTSD)

6) Please note that CNS only provides evaluations for medical treatment purposes and NOT for the following:
   a. Social security disability
   b. Litigation/Workman’s compensation
   c. Citizenship exam accommodations
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PATIENT DEMOGRAPHIC INFORMATION:
Name: ___________________________________________ Date of Birth: ________________________________
Gender given @ birth: ___________________ Gender Identity: __________________ 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) ____________________________________________