Child or Adult Neuropsychological Provider Referral Form

Patient Demographics

Name: _____DOB:_____

Address: _____

Contact: _____Phone:_____

Referring Provider

Name: _____Contact # _____

Address: _____Fax # _____

Release on file? Y/N (please send with referral)

REFERAL QUESTION**: What do you hope this evaluation will clarify? What is your main concern as a provider for this client?**

_____

_____

_____

THE FOLLOWING MUST BE COMPLETED:

Neuropsychological assessment is a specialized clinical assessment of the recipient's underlying cognitive abilities related to thinking, reasoning and judgment. Please note your concerns in the space below:

____A brain disorder is known or strongly suspected to exist because of the patient's medical history or a neurological evaluation and includes the following:

____Brain disorder resulting from past significant head trauma (TBI) A significant behavioral change, memory loss or other organic brain injury

____Brain tumor

____Stroke, Neoplasms or vascular injury of the central nervous system

____Seizure disorder

____Neurodegenerative disorder, Multiple sclerosis

____Brain disorder resulting from significant exposure to neurotoxins, Exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction, Central nervous system infection or other infectious disease

____Metabolic or toxic encephalopathy

____Fetal alcohol syndrome

____Congenital malformations of the brain

____Cerebral anoxic or hypoxic episode (including birth anoxia and cord concerns)

____Neurodegenerative disorder, Demyelinating disease, Extrapyramidal disease

____Systemic medical condition known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathies, cardiac anomalies, sickle cell disease and related hematologic anomalies, and autoimmune disorders such as lupus erythematosus or celiac disease

____Congenital, genetic, or metabolic disorder known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes or congenital hydrocephalus

____Severe or prolonged malnutrition or malabsorption syndrome

____ Dementia or vascular concerns

____Suspected neuropsychological impairment in addition to functional psychopathology such as substance abuse or dependence

____Other:_____

____Cognitive or behavioral symptoms suggest the recipient has an organic condition that cannot be readily attributed to functional psychopathology including the following:

____Poor memory or impaired problem solving
____Change in mental status evidenced by lethargy, confusion or disorientation
____Deterioration in level of functioning
____Marked behavioral or personality change
____A significant mental status change that is not a result of a metabolic disorder and has failed to respond to treatment
____In children or adolescents, significant delays in acquiring academic skill or poor attention relative to peers
____In children or adolescents, significant plateau in expected development of cognitive, social, emotional or physical function relative to peers
____In children or adolescents, significant inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional or physical demands.
____Other_____

____Condition presenting in a manner making it difficult for a clinician to distinguish between the following:

____ Neurocognitive effects of a neurogenic syndrome (such as dementia or encephalopathy) and
____Major depressive disorder when adequate treatment has not resulted in improvement in neurocognitive functioning, or another disorder (for example, autism, selective mutism, anxiety disorder, or reactive attachment disorder)
____Other_____

____ Concerns regarding Differential diagnosis and/or personality disorders (Psychological Testing only)

____ADHD vs other disorder
____ Current level of functioning
____ Second Opinion
____ General Ability and functioning levels
____Determine the status of the clients emotional, intellectual, and emotional functioning

PROVIDER SIGNATURE_____DATE_____

*****Please fax any pertinent neuroimaging, medical records, or past evaluations with this referral (preferably from birth to current date if available).******