# NEUROPSYCHOLOGY/ PSYCHOLOGY CONSULT FAX SHEET

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1704 N Hampton Rd # 204, Desoto, TX 75115
FAX: 469-208-0240 TEL: 469-444-3226

**Referring Physician's Name:** _____ Date: _____
Phone: _____ Fax: _____

**Patient Name:** _____ DOB:_____ ☐ Male ☐ Female
Tel: _____ Patient Address _____
_____

**Primary Insurance** _____ Contact Number _____
Contract Number _____ Policy Number _____

**CONSULT FOR**
☐ **Neuropsychological Evaluation** ☐ **Psychological Testing** ☐ **Psychological Therapy**

**REASON FOR CONSULT** ☐ **Legal Involvement**

- ☐ Cognitive and functional decline/ deficits
- ☐ Placement concerns/ Rehabilitation
- ☐ Mood, anxiety/ other psychiatric problems
- ☐ Diagnostic clarity _____
- ☐ Other _____

- ☐ Decision making capacity/ guardianship/ POA concerns

**POSSIBLE DIAGNOSTIC CONSIDERATIONS**

- ☐ Rule out possible Alzheimer's/ Vascular/ LBD/ FTD
- ☐ Possible early Dementia vs. Mild Cognitive Impairment
- ☐ Dementia vs. Depression/ Rule out pseudo dementia
- ☐ ADHD
- ☐ Developmental disorders/ Autism
- ☐ IQ/ IDD/ Learning disorders
- ☐ TBI/ Head injury/ Concussion/ CVA
- ☐ Pre and/or Post surgical evaluation
- ☐ Seizure disorder
- ☐ Neurological condition/ MS/ MSA/ Parkinson's
- ☐ Possible addiction/ addiction treatment
- ☐ Chronic pain evaluation
- ☐ Medical condition/ Malignancy
- ☐ Possible Exaggeration/ Malingering

**BRIEF REASON/ OTHER REASONS FOR CONSULT** _____
_____
_____

**Physician Signature** _____ Date_____

**INSTRUCTIONS:**

- **Please check all the above that apply**
- **Please FAX this sheet to 469-208-0240**
- **Please attach the following:**
  1. **Patient face sheet with insurance information**
  2. **History/ Summary of evaluation with current diagnosis and medications**
  3. **Imaging reports MRI/ CT/ PET/ previous Neuropsych/ Psychological reports, if any**