2000 Hogback Road, Suite 2, Ann Arbor, MI 48105
1056 Charles Orndorf Drive, Suite G, Brighton, MI 48116
500 Perry Road, Suite 202, Grand Blanc, MI 48439
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REFERRAL FOR NEUROPSYCHOLOGICAL EVALUATION

Date of referral: ________________________________

Patient's full name: ____ **Date of birth:** ________________________

Parent/Guardian/Authorized Representative's name: ____
(If applicable)

Phone: _____________________________ **Okay to leave message?** ☐ Yes ☐ No **Email:** _______________________________

Address: ____

City: ____ **State:** ______________ **Zip:** _____________________________

Insurance plan: _____________________________________ **Is this a Medicaid plan:** __________________________________

Please evaluate for the following (please check all issues that may be contributing to patient's presentation):

☐ ADHD[1] ☐ Anxiety ☐ Autism Spectrum ☐ Bipolar ☐ Depression ☐ Dementia/Cognitive Decline
☐ Obsessive/Compulsive Tendencies/OCD ☐ Cognitive/Intellectual Impairment ☐ Traumatic Brain Injury
☐ Learning Problems in Reading, Writing, or Mathematics ☐ History of Trauma or Abuse or Neglect ☐ Sleep Problems
☐ Premature Birth ☐ Fetal Alcohol/Drug Exposure ☐ Other: _________________________________

[1]Note. Patient's insurance company may not cover evaluation of ADHD unless patient's presentation is complicated by some of the issues above.

Referral question:

Relevant health or mental health history:

Requesting Physician (name): ____

☐ Primary Care Physician ☐ Psychiatrist ☐ Neurologist ☐Other: ____________________________________

Physician contact number: ______________________________________ **Office fax:** ___________________________________

____ ____
Referring Physician's signature Date

*****PLEASE SEND A RECENT VISIT NOTE OR CLINICAL SUMMARY/ BRAIN IMAGING REPORTS/RELEVANT LAB STUDIES*****