Department of Rehabilitation
Psychology & Neuropsychology
785 Mamaroneck Avenue
Billings Building, First Floor
White Plains, NY 10605
Phone: 914-597-2331
Fax: 914-597-2794

Outpatient Referral Form
Neuropsychological Assessment

Please fill out all information to facilitate the referral process. Please attach most recent clinic note, medical problem list, imaging results, and/or medication list as available.

Patient Information:

Name: _____ MRN# (if applicable): _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F _____ Primary Language: English Spanish Other: _____

Address: _____

Primary Phone#: _____-_____-_____ Name of Legal guardian/conservator (*if applicable*): _____

Referral Information:

Reason(s) for referral: TBI Concussion Stroke AVM Tumor Cognitive difficulties/changes Diagnostic clarification
(circle all relevant) Transplant Dementia Epilepsy/Seizure Personality concerns/changes Mood disorder Other psychiatric illness
Other: _____

Current Diagnosis: _____ ICD-10 code (*if applicable*): _____

Is the evaluation needed for return to work/school planning? Yes No

If yes, what is the anticipated date for return to work/school: ____/____/_____

Is the evaluation needed for return to driving? Yes No Is the evaluation needed to inform rehabilitation therapies? Yes No

What current symptoms suggest the need for neuropsychological evaluation? _____

_____

Specific questions to be answered: _____

_____

Insurance Information: Please complete and include insurance card copy (back and front) to expedite referral (if external).

1. Insurer: _____ Ins ID#:_____ Grp#:_____

Policy holder's name: _____ SSN: ____-_____-_____

Date of Birth: _____/_____/_____ Phone: _____-_____-_____

2. Secondary Insurance: Yes No

If yes, Insurer: _____ Ins ID#:_____ Grp#:_____

Referrer:

Requested by: _____Requested Date: _____/_____/_____

Address: _____

Phone: _____-_____-_____ Fax: _____-_____-_____ Referrer Signature: _____