



NEUROPSYCHOLOGICAL ASSESSMENT REFERRAL

Referring Provider: _____

Referring Provider Phone: _____ Fax: _____

Patient Name: _____ DOB: _____ Phone: _____

Patient Address: _____

Insurance Company: _____

Insurance ID#: _____

Subscriber, if other than patient: _____

Subscriber's birthdate: _____

Reason for Referral (please check appropriate category or describe symptoms) :

- Traumatic Brain Injury
- Dementia, Mild Cognitive Impairment, or concerns about memory loss
- Stroke
- Parkinson's disease
- Epilepsy
- Prenatal alcohol or drug exposure
- Prematurity or other birth complications
- Autism
- ADHD
- Intellectual disability
- Learning disability
- Other _____

Presenting symptoms or other comments:

Please include any relevant medical records, especially findings from EEG, CT, or MRI.

Be aware that no insurance company covers the cost of learning disability assessment. We do test for learning disability, but it is an out of pocket expense.