PSYCHOLOGICAL
SERVICES GROUP, LLC

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NEUROPSYCHOLOGICAL EVALUATION REFERRAL FORM

Referring Provider: _____ Provider Contact:_____

Patient Name: _____ Date of Birth: _____

Gender: Male or Female Patient Phone Number: _____

Is there a Guardian? Y N If yes, Name and Phone Number: _____

Patient Address: _____

Insurance Carrier: _____

Purpose of the referral for a Neuropsychological Evaluation:

☐ Assessment of neurocognitive abilities following head injury, stroke, neurosurgery, etc.

☐ Assessment of neurocognitive functions for assisting in the development of rehabilitation and/or treatment plan for persons with diagnosed neurological disorders.

☐ Differential diagnosis between psychogenic and neurogenic syndromes.

Provider concerns (please check all that apply):

Please note: Insurance carriers do not cover evaluation for only ADHD

☐ Head Injury ☐ Substance Misuse ☐ Psychosis ☐ Medical Diagnosis ☐ Language Impairment

☐ Prenatal exposure ☐ Memory Concerns ☐ Executive Functions ☐ Cognitive Changes ☐ Dementia

☐ Intellectual Disability ☐ Seizures ☐ Sleep Problems ☐ Mood Instability ☐ Other: _____

Relevant previous/current health or mental health history: _____

_____

_____

ICD-10 Code (for prior authorization): _____

Does the patient need any accommodations?

□ Communication □ Language □Vision/Hearing □Physical Disability □ Other_____

Referral signature: _____ Date: _____

***It will be important to send documents including but not limited to the patient's history, chart notes, or discharge summaries.

Please email the referral form to drstocker@PSGofAlaska.com or fax to (907) 865-2474