Neuropsychological Testing Referral Information

Adult Form

OCEANSIDE
COMMUNITY SERVICES, LLP

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	Referred by:	DOA:	OCS #:

Patient Name: Pronoun(s):	D.O.B.:	Age:	Gender:
Patient Address:			

Patient Contacts: / OK for communication?	Secondary Insurance:
☐ Phone: ☐ Cell: ☐ ☐ Email: ☐ Check preferred method of contact	☐ MaineCare ☐ Other Secondary Insurance ID No: ______________________
Language: **Interpreter needed?**	
Primary Insurance: ☐ MaineCare ☐ BCBS ☐ Aetna ☐ Cigna ☐ Medicare ☐ Medicare Advantage Plan Primary Insurance ID No: ______________________	******A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARDS ARE REQUIRED TO PROCESS THIS REFERRAL****** ***Please attached copy when submitting this form.***

Primary Care Physician	Name:	Phone: Fax:
Neurologist:	Name:	Phone: Fax:
Other Professional:	Name: Type:	Phone: Fax:
Reason for Referral	Current concerns/ Identified Issues / Duration of problems / Progress in treatment	

Current Diagnoses:		**Current Medications:**	

Cognitive Concerns Check all that apply	☐ Mild Cognitive Decline ☐ Adult ADHD ☐ Cognitive deficits / possible Dementia ☐ Traumatic brain injury / concussion ☐ Other Neurological Disorders: ______________________ ☐ Memory / Learning ☐ Language / Communication ☐ Sensory loss or disruption ☐ Attention / Concentration ☐ Academic Skills / Learning disabilities ☐ Executive Processing ☐ Confusion / Periods of cognitive change ☐ Other Cognitive Issues: ☐ Reasoning / Problem solving ☐ Visual Spatial Processing ☐ Motor Functioning ☐ Social Cognition / Autism symptoms ☐ Judgment / Decision making ☐ Psychiatric cognitive interference
Other Concerns Check all that apply	☐ Depression ☐ Mood swings / Emotional regulation ☐ Impulsivity / Erratic behavior ☐ Hallucinations / Perceptual Illusions ☐ Comorbid psychiatric disorders (list): ☐ Other (describe): ☐ Anxiety ☐ Anger / Irritability ☐ Suspicion / Paranoia ☐ Withdrawal / Isolation
Referring Person Info	Name: Relation: ☐ Phone: ☐ Cell: ☐ Fax: ☐ Email: Check preferred method of contact
Cancellation List	☐ Should be placed on a list for an earlier appointment if we have a cancellation. ***Requires completed intake paperwork for scheduling**. **Call to request intake paperwork**

Please include any available relevant documentation to this referral for Neuropsychological Testing: *Previous Psychological/Neuropsychological Evaluation Reports, Medical Notes, as well as any available diagnostic reports: CT scan, MRI, EEG*