

Neuropsychological Assessment Referral Form

Provider Name:
Phone:
Fax:

Patient Name:	DOB:
Phone/Contact:	Sex at Birth: Male Female
If there is a Guardian, Name:	Phone:
Patient Address:	

Insurance Carrier & Number: _____

Please note, "IHS" is not an insurance plan, but Tribally-Sponsored Health Insurance is (T-SHIP)

Referral ICD-10 Codes: _____

ADHD (F90.X) alone is not covered by insurance companies

Referral Purpose for the Neuropsychological Evaluation:

- Assessment of neuropsychological status following an acute event (e.g., CVA, TBI, or Toxic Exposure)
- Assessment of neuropsychological status to assist in rehabilitation and/or treatment of a diagnosed neurological disorder.
- Assessment of known or suspected neurodevelopmental disorder(s)
- Differential diagnosis between psychogenic and neurogenic syndromes.
- Establish neurocognitive baseline and/or compare to prior evaluation(s)
- Presurgical evaluation, Procedure: _____
- Division of Vocational Rehabilitation (DVR)

Presenting Concerns/Relevant History:

Accommodations Needed: Speech-Language Vision Hearing Physical Disability Other

Provider Signature: _____ Date: _____

Please also attach any recent chart notes, H&P reports, or discharge summaries.

FAX to (907) 615-3478 or secure email info@neurowest.com

A photocopy of this document is considered to be as valid as the original.