Neuropsychological Testing Referral Information

Adult Form

***We cannot accept referrals for:**

- **parental capacity evaluations**
- **Clients with an open court case during an evaluation**
- **Clients who are non-verbal**

OCEANSIDE
COMMUNITY SERVICES, LLP
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Please include any relevant records: brain scans, EEG reports, Psychological or Neuropsychological reports, or relevant legal records

Date:	Referred by:	D.O.B.:
Patient Name: Pronoun(s):		Age: Gender:
Patient Address:		
Patient Contacts: ☐ Phone: ☐ Cell: ☐ Email: Check preferred method of contact		**Secondary Insurance:** MaineCare: Other:
Primary Insurance: ☐ MaineCare ☐ BCBS ☐ Aetna ☐ Cigna ☐ Medicare ☐ Medicare Advantage Plan Primary Insurance ID No: _____		Race: Language: Interpreter needed? ☐ Yes ☐ 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 List all relevant information on this form,	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 to be added to our cancellation list.**

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*