Neuropsychological Testing Referral Information

Child Form

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We Cannot Test Clients Who Are Non-Verbal

Date:	Referred by:			
Child's Name: Pronouns:	D.O.B.:	Age:	Gender:	Grade:
Parent/Guardian:	Guardian address:			

Guardian Contacts:

☐ Phone

☐ Cell:

☐ Email:

Language: _____

Interpreter needed? ☐ **Yes** ☐ **No**

Primary Insurance (Circle)

⇨ ☐ MaineCare
⇨ ☐ BCBS
⇨ ☐ Aetna
⇨ ☐ Cigna

Primary Insurance ID No: _____

Secondary Insurance

☐ MaineCare

☐ Other

Secondary 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:
Psychiatrist:	Name:	Phone: Fax:
Counselor/ Therapist:	Name:	Phone: Fax:
Caseworker/ Case Mgr:	Name: Type:	Phone: Fax:
Other Professional:	Name: Type:	Phone: Fax:
School:	Name: ☐ Homeschooled	District:

Current Diagnoses:		**Current Medications:**	

Current Services Check all that apply	☐ School IEP/Special Ed ☐ School 504 Accommodations ☐ School Counselor ☐ Tutoring ☐ Occupational Therapy ☐ Speech Therapy ☐ Physical Therapy ☐ Vision Therapy ☐ Naturopathy ☐ HCT ☐ BHP ☐ VRT ☐ MST ☐ Psychotherapy ☐ Behavior Therapy (e.g., ABA) ☐ Group Therapy ☐ Social Skills training ☐ Other- Describe:
Current Status Check all that apply	☐ DHHS Involvement ☐ Foster Care ☐ Adoption Process ☐ Incarcerated ☐ JSOP/Probation Supervision ☐ Other:
Reason for Referral	Current concerns/ Identified Issues / Duration of problems / Progress in treatment
Cognitive Concerns Check all that apply	☐ General Intellectual Abilities ☐ Academic Skills / Learning disabilities ☐ Language / Communication ☐ Sensory Processing ☐ Auditory / Phonological Processing ☐ Reasoning / Problem solving ☐ Executive Processing (sequencing, shifting between tasks, working memory, processing speed, multi-tasking, etc.) ☐ Attention / Concentration ☐ Memory / Learning ☐ Visual Spatial Processing ☐ Motor Functioning ☐ Social Cognition ☐ Judgment / Decision making ☐ Other cognitive concerns Describe:
Other Concerns Check all that apply	☐ Traumatic brain injury / concussion ☐ Birth Injury ☐ Anxiety ☐ Depression ☐ Anger ☐ Poor social skills / no friends ☐ Other concerns- Describe: ☐ Substance Abuse in pregnancy ☐ Autism characteristics ☐ Moodiness / Emotional dysregulation ☐ Obsessive or compulsive behaviors ☐ Oppositionality / Defiance ☐ Sexual misbehavior
Person Referring	Name: Relation: Phone: Cell: 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 of the following documentation with the referral: the most recent medical examination note, as well as any relevant records: brain scans, EEG reports, Psychological or Neuropsychological reports, OT, PT, or SLP evaluations, school 504 plan or IEP, or DHHS or legal records