Neuropsychological Testing Referral Information

Adult Form

Accepting FULL Mainecare, Medicare, or BCBS Insurance Only

OCEANSIDE
COMMUNITY SERVICES, LLP

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Date:	Referred by:	DOA:	OCS #:
Patient Name:	D.O.B.:	Age:	Gender:
Patient Address:			

☐ Phone: ☐ Cell: ☐ OK - appt reminder text? ☐ Email: ☐ OK for communication? Check preferred method of contact	Insurance: ☐ Medicare ☐ BCBS ☐ MaineCare ID No:

Primary Care Physician	Name:	Phone: Fax:
Neurologist:	Name:	Phone: Fax:
Other Professional:	Name: Type:	Phone: Fax:

Current Diagnoses:		**Current Medications:**	
Reason for Referral	Current concerns/ Identified Issues / Duration of problems / Progress in treatment		

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Reason for Referral (Continued)	
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
Follow-up Date:	Date of Next Neurology Appointment: Other Critical Date to Receive Neuropsych Report:
Please send documentation of the referral for Neuropsychological Testing and the most recent Neurological Examination, as well as any available diagnostic reports: CT scan, MRI, EEG, sleep study	
Office Use	☐ Approved ☐ Not within guidelines. Reason: Initials: ☐ Insurance Confirmed History Form: ☐ Neuro Only ☐ NeuroPsych ☐ Senior Neuro Only ☐ Senior NeuroPsych ☐ Registration/LHQ sent:_____ Initials: ____ Revised: 9/27/18