Neuropsychological Testing Referral Information

Child Form

Accepting FULL Mainecare, Medicare, or BCBS Insurance Only

OCEANSIDE
COMMUNITY SERVICES, LLP

22 West Cole Road, Unit 103
Biddeford, ME 04005
P: 207.571.9923 F: 207.571.9927
www.oceansidecommunityservices.com

Date:	Referred by:		DOA:	OCS #:
Child's Name:	D.O.B.:	Age:	Gender:	Grade:
Parent/Guardians:	Guardian address:			
Guardian Contacts: ☐ Phone: ☐ Cell: ☐ Email: Check preferred method of contact	OK for communication? ☐ ☐		Patient Insurance: ☐ Mainecare ☐ BCBS ID No:	
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
Office Use	☐ Approved ☐ Not within guidelines. Reason: Initials: ☐ Insurance Confirmed ☐ Registration/LHQ sent:_____ Initials: ____ Revised: 8-24-17