Carolina Neuropsychological Service, Inc.

Neuropsychology & Rehabilitation Psychology
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REFERRAL INTAKE FORM

Patient Name: _____ **Parent Name** (for child patients): _____
Patient's Address: Street:_____
City:_____**State:**_____**Zip:**_____
Home #)_____ _____ **Wk #)** _____
Cell)_____ **Patient's DOB**: _____- _____-_____
SSN: _____-___-_____
Referring Doctor, Practice Name & Number: _____
_____
Doctor/PA NPI #: _____ **Contact:** _____

Reason for Referral: "Please assess the integrity of Central Nervous System functions in light of medical history of the following" (check all that apply and circle chief referral concern).

_____ Concussion (__Sports__Fall__Other)
_____ Head Injury
_____ Stroke (Adult or Perinatal)
_____ Birth/Perinatal Complications
_____ Epilepsy/Seizures
_____ Encephalopathy
_____ Abnormal EEG or MRI
_____ Other: (Specify) _____

_____ Migraine/Headaches
_____ Memory Problems
_____ Attention/Focus Problems
_____ Optimal Performance
_____ Cogmed Working Memory Training
_____ Autism Spectrum Disorder
_____ Learning/Academic Problems

(Please note that Cogmed Training and Educational Testing are not considered "medically necessary" and are not reimbursed by most insurance companies. They will usually be an out-of-pocket expense.)

Dx(s) to Verify 1)_____ 2) _____

3) _____ 4) _____ 5) _____

Primary Insurance Coverage:

Carrier: _____ **Phone:** _____

M/H Carrier: _____ Phone:_____

Insured: _____ Patient Type: _____

ID #:_____ **Group #:** _____
NOTES: _____
_____

PLEASE ATTACH YOUR DEMOGRAPHIC SHEET & COPY OF PATIENT'S INSURANCE CARD THANK YOU!!!