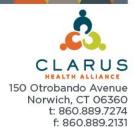
## **Neuropsychological Testing Referral Form**



Referring Provider:		NPI:	150 Otrobando Avenu
Organization:	Phone:		Norwich, CT 0636
Patient Information:			
Last Name:	First Nam	ne: DOB:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Gender: M	F Trans NB
Contact (if other than patient, **Please specify if patient is ur	): Pho nder guardianship or conservatorship**	one: Relationship	o:
Insurance Information:			
Primary Insurance Carrier: _	ID#:	Group#:	
Subscriber Name:	DOB:	: Relationship:	
Secondary Insurance Carrie	r: ID#:	Group #: _	
Subscriber Name:	DOB:	: Relationship:	
Reason for Referral (check	all that apply):	Desired Recommendations (check all	that apply):
Assist with diagnosis Assist with specific differ Evaluate current function Assess for contribution of Assess capacity for decis Establish cognitive basel Compare to a prior eval	ning/strengths/limits of psychological factors ion-making	☐ Treatment recommendation ☐ Daily functioning (e.g., driving) ☐ Placement (e.g., long term care) ☐ Work ☐ Academic ☐ Suitability for surgery/intervention ☐ Other:	
Patient Complaints:  Anxiety/Depression/Modelinattention Confusion Hypoactivity/Hyperactiv Agitation/Aggression	od instability Atypical behaviors Learning/Academic pro Problems with social sl ity Autism related concern Self-injurious behavior	kills/behaviors Psychosis/Hallucinal	ctioning
Provider Concerns:		_	
Cognitive Attention Processing Speed Language/Speech Visuospatial Memory Executive Functioning Judgement/Insight Symptom Validity	Psychological Depression/Anxiety Hallucinations/Delusions/Paranoia Personality change Substance misuse Sleep problems Behavior Disturbance Social Challenges Previous Dx: Other:	Possible a	Stroke ack Cancer ity Seizures
Additional information reg	arding referral or any specific requests re	egarding the consult:	

<sup>\*</sup>Please fax all relevant office notes, problem list, previous evaluations, medications, labs, neuroimaging results, etc. Thank you for the referral.\*

## **Neuropsychological Testing Referral Guidelines**



**Referring Providers:** Please read the following information to help determine whether neuropsychological services are medically necessary for your patient (as required for insurance reimbursement). The following information is provided as a guideline for completing referrals. Please read carefully, as referrals may be delayed or denied if these guidelines are not followed. Every referral is closely reviewed by our staff.

- Please be aware that Clarus Health Alliance is not able to accept neuropsychological testing referrals for
  patients without cognitive concerns or changes in functioning. For example, patients only exhibiting
  psychiatric concerns should instead be referred for psychiatric evaluation or treatment prior to
  neuropsychological services.
  - Psychological testing is best differentiated from neuropsychological testing in that the purpose of the psychological evaluation is to provide diagnostic impression of psychiatric conditions, such as depression, anxiety, bipolar, schizophrenia, etc. In contrast, neuropsychological testing is often required for individuals with known or suspected neurological compromise as well as learning disorders and neurodevelopmental conditions. In these evaluations, the primary focus is on assessing and characterizing an individual's attention, processing speeds, language skills, visual skills, memory, and executive functioning.
- 2. If this is a referral for a patient with a known psychiatric condition who is not yet psychiatrically stable (for example, a patient with ongoing bipolar disorder or PTSD), please refer the patient for further psychiatric evaluation or treatment *prior to* a referral for neuropsychological services.
- 3. Please note Clarus Health Alliance does not provide psychiatric treatment services such as medication management or pain management. Clarus Health Alliance *does* offer psychotherapy services for clients ages 14 and older. Please see the "resources" tab on our website (<a href="www.clarushealthalliance.com">www.clarushealthalliance.com</a>) for our office's Psychotherapy Referral Form.
- 4. In addition to completing the referral form entirely, please attach recent medical records (office notes, problem list, medications, labs, neuroimaging results, previous neuropsychology reports, etc.) describing cognitive and/or emotional issues.

Once medical records, patient demographics, and insurance information are received, our office will be able to proceed with scheduling your patient. If the referral is incomplete, it may be denied and returned.

Please fax your referral to 860-889-2131. Should you have any questions, please call the office at 860-889-7274. We appreciate working with you and look forward to providing services for your patients.