

Neuropsychology Assessment Center at BIDMC
Dept. of Psychiatry
Referral Form: Neuropsychology Referrals Only

Phone: 617-632-0908 Fax: 617-754-8638 neuropsychology@bidmc.harvard.edu **DATE:**

| | | | |
|------------------|--|---------------------|--|
| Patient's Name: | | Referring Provider: | |
| Patient's Phone: | | Referral Fax: | |
| pt email address | | Referral Phone: | |
| DOB | | Institution/Clinic | |

A. What question would you like the neuropsychological assessment to answer?

B. Cognitive complaints/symptoms:

C. Causes/contributing factors suspected (indicate all):

Neurologic (eg. TBI, dementia PD, CVD, MCI, etc.)

Infectious (e.g. HIV, Liver Disease, Lyme etc.)

Substance Abuse

Development (ADHD, NVLD, Reading d/o, MR, etc.)

Psychiatric (Mood d/o, anxiety, schizophrenia spectrum, etc)

Does patient have:

Chronic Pain?

Safety Concerns?

Comments:

D. How might the assessment assist treatment (check all that apply)

A. Treatment planning/management

B. Diagnostic Clarification

C. To explain patient's complaints