Neuropsychology Assessment Center
BIDMC Psychiatry (HMFP)
Referral Form

Phone: 617-667-4749 Fax: 617-754-8638 neuropsychology@bidmc.harvard.edu **DATE:**

Patient's Name:		Referring Provider:	
Patient's Phone:		Referral Fax:	
DOB:		Referral Phone:	
MR# (BID) or SS#		Institution/Clinic	

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

B. Cognitive complaints/symptoms:

Does patient have:
1. Chronic pain? Y N
2. Any current concerns for pt. safety we should be aware of? Y N

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

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

☐ **Infections** (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)

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**