Arbor Mental Health Center
500 N. 3rd St., Suite 220
Wausau, WI, 54403
Phone: (715) 204-4260
Fax: (844) 927-0227
Email: ContactUs@ArborCenter.org

IMPORTANT
Please Send Copy of Patient's Insurance Card With Referral

NEUROPSYCHOLOGICAL EVALUATION REFERRAL FORM

Please provide as much of the following information as possible.
After you have sent the referral, your patient is welcome to call our office to schedule an appointment.

PART I: REFERRING PROVIDER INFORMATION	
Referring Provider:	
Practice Name:	☐ Primary Provider ☐ Other:
Phone:	Fax:

PART II: PATIENT INFORMATION	
Patient Name:	Gender:
Date of Birth:	Parent/Guardian:
Insurance:	Phone:
Address:	

PART III: REFERRAL QUESTION

Date of last passed hearing screen: _____. Date of last passed vision screen: _____.
Please describe specific problems/symptoms and diagnoses:

Is this evaluation medically necessary? No ☐ If YES, please indicate which of the following applies:

☐ Assessment of neurocognitive abilities following traumatic brain injury, stroke, or neurosurgery or relating to a medical diagnosis, such as epilepsy, hydrocephalus or AIDS.

☐ Assessment of neurocognitive functions to assist in the development of rehabilitation and/or management strategies for persons with diagnosed neurological disorders.

☐ Differential diagnosis between psychogenic and neurogenic syndromes.

☐ Monitoring of the progression of cognitive impairment secondary to neurological disorders.

☐ Other. Please explain in above referral question.

ICD-10 Code(s) (for insurance prior authorization):

Does the patient have any of the following limitations: (check) ☐ Communication
☐ Language ☐ Vision ☐ Hearing ☐ Physical Disability ☐ History of Head Injury

Today's Date:_____	Referring Provider Signature:

***Please send any recent chart notes, history and physical reports, or discharge summaries.