Referral For Neuropsychology

Central Scheduling

PH: 937-641-3128 Fax: 937-641-6140 Toll Free Fax: 866-891-6941

One Children's Plaza • Dayton, OH 45404-1815 • childrensdayton.org

PLEASE PRINT (ALL INFORMATION IS REQUIRED)

Date of Request: ______________________________

PATIENT INFORMATION

Patient's Name: ____

☐ M ☐ F DOB: ________________________________

Parent/Guardian Name(s): ____________________________

Home Phone: ____

Cell Phone: ________________ Work Phone ______________

Email address: ______________________________________

Preferred Contact Phone: ☐ Work ☐ Cell ☐ Home

Do You Need an Interpreter? ___________________________

Language: ____

Patient is in custody of: ☐ Parents ☐ Guardian ☐ CSB

Address: ____

City: _________________ State ___________ Zip ___________

1st Insurance: _________________ ID# ___________________

Precert # ____

2nd Insurance: _________________ ID# ___________________

Precert # ____

REQUESTING PROVIDER GROUP:

Office name ____

Provider name ____

Office location ____

Office contact person ___________________________________

Phone _____________________ Fax _____________________

Signature ____

Our goal is to process referrals within two business days.
If unable to contact family within one week,
we will notify your office.

****Neuropsychological testing is not valuable for most children with a global developmental delay because the absence of cognitive variation pre-empts the goal of addressing structural involvement, related functional sequela, and the ability to develop meaningful, profile-specific recommendations.****

REASON FOR REQUEST

Diagnosis Code/Reason for request: ____

Does the child have a medical diagnosis or medical history that has impacted the child's brain development or current CNS status?

☐ Yes ☐ No

If yes, *check from list below:*

- ☐ Brain mass or other CNS abnormality, e.g., Chiari malformation, tuberous sclerosis
- ☐ Epilepsy
- ☐ Cancer
- ☐ TBI
- ☐ Blood Disorder (be specific, e.g., SCD dx): ____________________________________
- ☐ Other (please provide diagnosis): ____

If no, *consider a referral for educational testing at school (parents may request this in writing) to assist with development of an intervention plan. Parents may also contact the Mental Health Resource Connection (MHRC) for additional resources at 937-641-4780.*

Is the evaluation needed pre-surgery or to assist with monitoring neurocognitive change associated with treatment, e.g., chemotherapy or radiation?

☐ Yes ☐ No **If yes**, *date of surgery, if known*: ______________________________

Is the patient known or suspected to have a global developmental delay or intellectual disability?

☐ Yes ☐ No **If yes,** *please consider a referral to the patient's local school district, MHRC 937-641-4780, or your county's Board of Developmental Disabilities*

Routine **Urgent** **Timed** **Stat**