

**OUTSIDE REFERRAL**

**REQUEST - PEDIATRIC**

**SECTION OF NEUROPSYCHOLOGY**

4505 Country Club Rd Suite 110

WINSTON SALEM NC 27104

**TELEPHONE:** 336-716-2261

**FAX:** 336-716-9810

**RETURN THIS APPOINTMENT REQUEST TO:**

Name/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT TO BE SCHEDULED:**

Name & Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUESTED SERVICE:** *(please check one or more of the following reasons for assessment/evaluation)*

**⬜** Neurodevelopmental

**⬜** Cognitive & Psychological Status Post **⬜**Neurological Injury (head injury, concussion, meningitis, etc.)

**⬜** Pre or Post Treatment Status (i.e chemotherapy, brain surgery, etc.)

**⬜** Genetics

**⬜** Diagnose ADD / ADHD

**⬜** Establish a baseline for patient w/ new neurological diagnosis

**⬜** 2nd opinion regarding neuropsychological diagnosis

**\*Is this service needed for educational accommodations? ⬜ YES ⬜ NO**

**The following items are REQUIRED to process a referral in our department. If all items are not received, it will delay the process for scheduling the patient.**

* Procedure Order signed by the ordering physician (include reason for referral)
* Last 3 office notes (applicable to requesting diagnosis)
* Copy of Insurance Care (front & back)
* Patient Demographics
* Guarantor Demographics including DOB
* Name of Primary Care Doctor
* Neurology Imaging Reports (MRI, CT of head, EEG, PET scan, etc.)
* Any ED, Hospital Admission Notes that are applicable to referring diagnosis

**PLEASE NOTE**

We CANNOT schedule a patient without the above information.

An appointment confirmation will be mailed to the patient & faxed to the ordering provider.