

# Consultation Request

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|--|---|
| <input type="checkbox"/> Neuropsychological Evaluation                                     | <input type="checkbox"/> Psychological Evaluation         |
| <input type="checkbox"/> Psychiatric Services<br>(Medication Management)                   | <input type="checkbox"/> Counseling/Behavioral Therapy    |
| <input type="checkbox"/> Addiction/Substance Use M.A.T.<br>(Medication-Assisted Treatment) | <input type="checkbox"/> Opiate/Addiction Risk Assessment |
|  | <input type="checkbox"/> VNS (Vagus Nerve Stimulation)    |

Date of Request: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Practice/Business Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

**Suspected/Confirmed ICD-10 codes associated with this patient referral:** \_\_\_\_\_

**\*For Neuropsychological/Psychological Evaluation, please indicate the following:**

- Consult for diagnostic clarity/facilitate diagnosis
- Consult to assist in distinguishing between emotional/behavioral vs. cognitive/neurocognitive problems
- Clarify neurocognitive status to inform treatment planning
- Monitor progression, recovery, and response to changing treatments  
Monitor the outcomes of current cognitive rehabilitation procedures
- Establish the presence of abnormalities or distinguish them from changes that may occur with normal aging, or the expected progression of other disease processes
- Other: \_\_\_\_\_

**Note: Failure to receive the information specified below may delay the scheduling process.**

- Please fax over the last 2 office visit notes and any additional records relevant to the referral.
  - Include any available imaging or relevant emergency treatment notes.
- If you require assistance filling this form, please call 810.275.9153 or text 810.321.4549