



Consultation Request

4800 S. Saginaw St. Suite 1900 Flint MI 48507

Phone: (810) 275-9153 **Fax:** (810) 213-0279 **Text:** (810)321-4549 **Email:** neuropsych@iinn.com

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

Date of Request: _____
Patient Name: _____ DOB: _____
Phone: _____

Referring Physician: _____
Practice/Business Name: _____
Phone: _____ Fax: _____

***Reason for referral:** _____

***Initial ICD-10 codes associated with this patient referral:** _____

For Neuropsychological/Psychological Evaluations, 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

[Note: Failure to receive the information specified above 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 need any assistance filling out this form, please call 810.245.9153 or text 810.321.45549