Dr. Lori Azzara, Clinical Neuropsychologist
Licensed Psychologist/HSP
Fax: 877-509-2367
NEUROPSYCHOLOGICAL TESTING REFERRAL SHEET

Date of Referral: _____ Age: _____

Name of Patient: _____ Date of Birth: _____

Name and facility of referring person: (if from other facility): _____

_____

Telephone # of person making the referral: _____

Reason for Referral (<u>please be specific</u>; question to be addressed by the evaluation):

_____

_____

_____

Has the patient had a previous (neuro)psychological evaluation (including IQ and/or academic)? Date(s): _____ Are the results available? Yes No

[Previous test results are crucial for a thorough evaluation. If the results are not already on file, please instruct the patient (parent or guardian) to request the results be sent to Dr. Lori Azzara.]

Current diagnosis (diagnoses) – include any/all current diagnose _____

_____

Current medications (list all, including dosage):_____

_____

Expected date of results: _____

<u>INSURANCE INFORMATION:</u>
MBHP # _____
BCBS # _____
UBH # _____
Authorization number (required) _____

<u>Private Pay Authorization:</u>
Name: _____
Address: _____
_____
Phone: _____