



2505 Anderson, Suite 101
Manhattan KS 66502-2853
tel: 785-236-1180/fax: 785-789-4048
flintheillsneuropsych.com

NEUROPSYCHOLOGICAL ASSESSMENT REFERRAL

Referring Provider: _____

Referring Provider Phone: _____ Fax: _____

Patient Name: _____ DOB: _____ Phone: _____

Contact Name for scheduling, if other than patient: _____

Patient Address: _____

Insurance Company: _____

Insurance ID#: _____

Subscriber, if other than patient: _____

Subscriber's birthdate: _____

Reason for Referral (please check appropriate category or describe symptoms) :

- ____ Traumatic Brain Injury
- ____ Dementia, Mild Cognitive Impairment, or concerns about memory loss
- ____ Stroke
- ____ Parkinson's disease
- ____ Epilepsy
- ____ Prenatal alcohol or drug exposure
- ____ Prematurity or other birth complications
- ____ Autism
- ____ ADHD
- ____ Intellectual disability
- ____ Learning disability
- ____ Other _____

Presenting symptoms or other comments:

Please include any relevant medical records, especially findings from EEG, CT, or MRI.

Be aware that no insurance company covers the cost of learning disability assessment. We do test for learning disability, but it is an out of pocket expense.