FRONTIER HEALTH AND WELLNESS

Release of Information Prep Form: Neuropsychological Testing Intake Packet

Please provide the following information to the best of your knowledge and ability

Hospital of Birth	Facility Name:	Address	Phone: Fax:	Dates in Hospital
Current School	School Name	Address	Phone: Fax:	Dates of attendance (MM/YY-MM/YY)
Any Previous School Attendance	School Name	Address	Phone: Fax:	Dates of attendance (MM/YY-MM/YY)
Any Previous School Attendance	School Name	Address	Phone: Fax:	Dates of attendance (MM/YY-MM/YY)
Pediatrician ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Occupational Therapist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Speech Therapist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Mental Health Therapist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Psychiatrist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)

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Previous Neuropsychological or Psychological Testing	Clinic: Provider:	Address	Phone: Fax:	Year of Evaluation
Neurologist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Gastroenterologist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Endocrinologist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Allergist/Immunologist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Pulmonologist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Nutritionist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Other Specialist	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Other Specialist	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)

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Urgent Care/Walk-In Clinic	Clinic: Provider:	Address	Phone: Fax:	Dates of Service
Hospital (admissions)	Facility Name	Address	Phone: Fax:	Admission Dates (MM/DD/YY-MM/DD/YY)
Psychiatric Hospital (Admissions)	Facility Name	Address	Phone: Fax:	Admission Dates (MM/DD/YY-MM/DD/YY)
Residential Treatment Center	Facility Name	Address	Phone: Fax:	Admission Dates (MM/DD/YY-MM/DD/YY)
Therapeutic Foster Care	Agency Used	Address	Phone: Fax:	Admission Dates (MM/DD/YY-MM/DD/YY)
Office of Children's Services	State Case Worker(s)	Address	Phone: Fax:	Date of Case Opening (MM/YY) Closed? ☐ Yes ☐ No
Department of Juvenile Justice	State Probation Officer(s)	Address	Phone: Fax:	Date of Case Opening (MM/YY) Closed? ☐ Yes ☐ No

Any Other Medical/Mental Health Treatment Providers or Facilities Not Listed Above

Provider/Facility Type	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Provider/Facility Type	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Provider/Facility Type	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)