FRONTIER HEALTH AND WELLNESS, LLC

Neuropsychological Testing

Patient Referral Form

Fax completed form as well as the requested clinical documentation to **855-595-2950.**

Attn: Neuropsychology

Date		
Referring Provider Name	NPI	
Practice/Clinic Name	Phone	Fax
Address		

Patient Full Legal Name (First, Middle Initial, Last)	Date of Birth	Age
Patient Preferred Phone Number	Preferred Pronoun	Sex

Guardianship (If guardianship is anything other than shared or 50/50 please provide custody agreement if available)

Parent/Guardian Name (1): Guardian listed above guardianship status: ☐ Shared ☐ Primary ☐ Sole	Parent/Guardian Name (2): Guardian listed above guardianship status: ☐ Shared ☐ Primary ☐ Sole
Phone Number	Phone Number

We Do Not Bill/Accept Denali KidCare, Medicaid or Medicare

This section is not needed if there are clear copies of the patient's insurance cards sent in the referral packet

Primary Insurance Carrier	Subscribers Name ☐ Same as patient	
Policy Number/Member ID	Group Number	
Patients Relationship to Subscriber	Subscribers Date of Birth	Last 4 of Subscriber SS#
Secondary Insurance Carrier	Subscribers Name ☐ Same as patient	
Policy Number/Member ID	Group Number	
Patients Relationship to Subscriber	Subscribers Date of Birth	Last 4 of Subscriber SS#

FRONTIER HEALTH AND WELLNESS, LLC

Neuropsychological Testing

Patient Referral Form

Please select your preferred provider:

☐ Dr. Rachel Woods
Woods Neuropsychological Services, LLC

☐ Dr. Erin Johnson
Alpine Assessments, LLC

☐ No Preference/1st available

Please select the primary reason for the referral:

☐ Assessment of Cognitive Functioning ☐ Diagnostic Clarification ☐ Treatment Planning

Please list the patients primary diagnosis codes:

_____

Please identify the primary symptoms and concerns that led to this referral:

☐ Anxiety
☐ Attention/Concentration
☐ Change in Gait
☐ Depression
☐ Executive Functioning
☐ Judgement
☐ Language/Communication
☐ Memory
☐ Mood
☐ Personality
☐ Processing Speed
☐ Reasoning Skills
☐ Sleep Problems/Disturbances
☐ Tremors
☐ Visuospatial Skills
☐ Other:_____

Please identify the medical/neurological conditions the patient is suspected of, has a history of, or is currently diagnosed with:

☐ Alzheimer's Disease
☐ Anoxic/Hypoxic Injury
☐ Autism
☐ Birth Complications or Exposure
☐ Concussion
☐ Delirium
☐ Dementia
☐ Epilepsy/Seizure
☐ Exposure to Toxin(s)
☐ Learning Disability
☐ Multiple Sclerosis
☐ Parkinson's Disease
☐ Stroke
☐ Traumatic Brain Injury
☐ Transient Ischemic Attack
☐ Other:_____

Please list any prior Neuropsychological Evaluations the patient has previously had (if any):

Type of Evaluation/Assessment	Date(s) of Evaluation	Administering Provider/Clinic

Please include the following documentation with the referral

- History and Physical
- Last 2 Clinical Notes
- Patient Demographic Sheet
- Copy of Patient Insurance and ID
- Discharge Summary (if applicable)
- Intake Assessment/Evaluation

Signature of Referring Clinician:_____ Date:_____

For more information or with any questions, call 907-222-6606
Fax completed form as well as the requested clinical documentation to 855-595-2950
Attn: Neuropsychology