INNOVATION
Behavioral Health Solutions, LLC
The Offices of Dr. Sandra Gray, Ph.D.

Neuropsychology / Psychology Referral Form

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Date of Referral _______________
Doctor's Office ______________________________ PHONE ________________ FAX_________________
Patient Name __________________________ DOB ___________ TEL _____________________
Contact Person Name ____________________________ Relationship______________ TEL __________________
Patient Address____
Primary Insurance ___________________________ Member Number: _______________________________
Diagnosis __________________________________ ICD Code (Required)______________________

Referral For (Please check one): ☐ Adult Neuropsychological Assessment ☐ Pediatric Neuropsychological Assessment

Please check all that apply:

☐ Legal Involvement
☐ Chronic Pain
☐ ADHD
☐ Learning Disorder
☐ Early / Mild Cognitive Impairment
☐ Pre-surgical Evaluation Deep Brain Stim
☐ Pre-surgical Eval other ___________________
☐ Concussion/Head Injury
☐ Possible Toxic/Medication Effects
☐ Post Stroke
☐ Possible Addiction
☐ Possible Exaggeration/Malingering
☐ Other: ________________________________
☐ Possible Dementia
☐ Dementia vs. Depression
☐ General Psychotherapy
☐ Addiction treatment
☐ Psycho-oncology
☐ Post DBS Evaluation
☐ Cancer Survivor
☐ TBI
☐ Possible Anoxic/Hypoxic
☐ Chronic Pain Evaluation
☐ MS
☐ Seizure Disorder

Referral Question:

Medicaid Patient Physician Certification:
I certify that I have examined the patient and that neuropsychological testing is medically necessary.

PHYSICIAN NAME	PHONE	FAX	NPI #

PHYSICIAN SIGNATURE/TITLE	NV LICENSE#	DATE	TIME

When possible **have patient sign and date the following:**

I ___________________________, authorize release of confidential psychological and other protected health information concerning this referral from the referral source to Innovation Behavioral Health Solutions, LLC (IBHS LLC) to contact me at the following number:____________________________. This release for establishing referral shall expire in 3 months from date of signature.

Patient Name:_____________________________
Signature_________________________________ Date_________________