

**PHYSICIAN REFERRAL FORM
FOR NEUROPSYCHOLOGICAL EVALUATION
CONSULTATION AND TREATMENT**

www.greatmindsmi.com

Date of Referral: _____ Name of Patient: _____

Date of Birth: _____ Referring Physician: _____

Phone: _____ Fax: _____

Name of Parent/Legally authorized representative: _____

Primary Contact Number: _____ Secondary Contact Number: _____

Reason for Referral:

Goals:

- Consultation
- Brief Evaluation

- Comprehensive Evaluation
- Therapy
- Other _____

Pertinent medical history and diagnoses (e.g., prematurity, low birth weight, concussion, head injury, language or motor disorder, genetic, endocrine, seizure disorder):

Reason for Evaluation or Treatment:

- Concussion/Traumatic Brain Injury
- Neurodevelopmental (e.g., autism, global developmental delay, intellectual disability)
- Attention, language, memory problems
- Emotional/behavioral (anxiety, depression, disruptive)
- Educational (learning disability, accommodations) Note: This is not billable to medical insurance if the primary reason

Patient Insurance:

- Blue Cross Blue Shield Traditional or PPO (Participating Provider)
- Out of Network for all others (Great Minds will provide information for patient claim submission)
- Self-pay

Documents faxed to 855-847-7656

- Prescription (required for billing health insurance)
- HIPAA Consent Form on file (required for coordination of care)
- List of medications
- Pertinent medical records

Referring Physician is requesting:

- Phone follow-up
- Brief Summary Letter
- Complete Evaluation Report

Contact Dr. Reed at 855-478-6467 if there are any questions. Great Minds will assist the patient by verifying insurance eligibility and estimating patient costs.