JAMES W. PIER, PH.D.
CLINICAL NEUROPSYCHOLOGIST

Referral for Neuropsychological Evaluation/Treatment

FAX to 203-272-1547 **or email** to: susan@jwpneuro-psych.com

Patient Name:_____ **Date of Birth:**_____

Diagnosis:_____

Reason for Referral:_____

Applicable Referral Questions: (check all that apply)

___ Please provide neuropsychological diagnosis.

___ Given the patient's condition, please provide clinical information related to the nature and severity of any cognitive, emotional or behavioral symptoms.

___ Please provide insights related to the status of basic ADLs and IADLs such as the ability to function in academic or vocational environments, driving, managing finances, etc.

___ Please provide information related to neuropsychological prognosis, emotional status, coping resources and indications for psychotherapy or cognitive rehabilitation.

Other:_____

***Please attach office notes that document condition and cognitive/emotional concerns

***Include neuroimaging studies if available

Referring Physician:_____ Referring Physician Fax:_____

Patient Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Number:_____ Work:_____

Insurance Co.:_____ Ins. ID#:_____

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