

NEUROPSYCHOLOGICAL TESTING

INTAKE SHEET

Patient Name: _____ Date of Birth: _____

We greatly appreciate your referral to the Drake Center Department of Medical Psychology and Neuropsychology for an evaluation. Our outpatient services currently include neuropsychological testing to determine the early effects of neurodegenerative disorders ("mild cognitive impairment"), dementia, and the cognitive consequences of other neurological and medical problems. We do not evaluate for the effects of psychiatric illness. To provide the best care for your patient, we ask that you provide us with the information requested below. If you have questions regarding types of testing, treatment or the information we are requesting, please contact us at 513-418-4725.

Referring Physician

Name: _____

Phone: _____

Where would you prefer that we send our final report?

Address: _____

City, State, Zip: _____

Or if you prefer:

Fax: _____

For what reason are you referring this patient to us for a neuropsychological evaluation?

Please fax the following to (513) 418-2618

- Patient Data Sheet
- Notes from the patient’s most recent visit
- Initial evaluation (patient’s first visit with the referring physician)
- Records of any previous neuropsychological evaluations
- Results of labs, CT/MRI, EEG, etc.
- Most recent MMSE (mini mental-state examination) and date administered
- Any other pertinent records

If you have any questions regarding the patient’s appointment or non-clinical questions, please contact our Outpatient Scheduling Department at (513) 418-2798

Signature of Person Completing Form

Date

For Internal use only

Records Complete for Scheduling

Date of Appointment: _____