Hospital for Special Care

2150 Corbin Avenue
New Britain. CT 06053
TELE: 860-827-4751
FAX: 860-832-6278

Department of Psychology Referral Intake & MD Order form

Please complete the entire form for referral processing

REFERRING PRACTICE/PHYSICIAN

NAME: _____ **PHONE:** _____
ADDRESS: _____ **FAX:** _____
_____ **EMAIL:** _____
PCP: _____ **PHONE:** _____

PATIENT INFORMATION

NAME: _____ **DOB:** _____ **GENDER:** ☐ M ☐ F
ADDRESS: _____ **PRIMARY TELEPHONE:** _____
_____ **EMAIL ADDRESS:** _____
LANGUAGE: _____
CONSERVED: ☐ YES ☐ NO **CONSERVATOR NAME:** _____
CONSERVATOR PHONE: _____

SECONDARY CONTACT ☐ / CONTACT FOR SCHEDULING ☐ (*Please check one)*
NAME: _____ **PHONE:** _____ **RELATIONSHIP:** _____

INSURANCE INFORMATION ***Insurance REQUIRES clinical documentation that supports the need for an exam)***

PRIMARY INSURANCE: _____ **MEMBER ID#:** _____
SECONDARY INSURANCE: _____ **MEMBER ID#:** _____
WORKERS COMP: _____ **CLAIM #:** _____
IS THIS RELATED TO AN MVA? _____

REFERRAL ☐ **TESTING** ☐ **TREATMENT**

CLINICAL INDICATION ***(please check all that apply)***

☐ COGNITIVE HEALTH (DEMENTIA) ☐ CONCUSSION ☐ CVA ☐ COGNITIVE DEFICITS
☐ ADHD/ADD ☐ TBI ☐ INSOMNIA (tx only) ☐ BEHAVIORAL CHANGES
☐ OTHER: _____

HISTORY OF ***(please check all that apply)***

☐ ADHD/ADD SUICIDALITY ☐ HEAD INJURY ☐ DEPRESSION/ANXIETY ☐ PSYCHIATRIC HOSPITALIZATION
☐ MEMORY CHANGES ☐ SUBSTANCE ABUSE ☐ COGNITIVE DEFICITS ☐ BEHAVIOR CHANGES
☐ OTHER: _____

PREVIOUS NPT ☐ Y ☐ N **IF SO, BY WHOM:** _____ **DATE:** _____

PLEASE INCLUDE THE FOLLOWING WITH YOUR REFERRAL: ***PLEASE LIMIT FAXES TO NO MORE THAN 50 PAGES***

Insurance REQUIRES clinical documentation that supports the need for an exam)

☐ PROGRESSS / OFFICE NOTES ☐ RADIOLOGY REPORTS(head only) ☐ PREVIOUS NEUROPSYCH EXAM
☐ HOSPITAL D/C SUMMARY ☐ SCHOOL RECORDS (WHERE INDICATED) ☐ SIGNED ORDER (MD or APRN)