Boston Children's Hospital
Neuropsychology

300 Longwood Ave, Fegan 8 (BCH3222)
Tel: (617) 355-8434 Fax:(617)730-0319

For administrative use only:
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Referral #:

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PATIENT INFORMATION

First Name:	Last Name:	MI:
Date of Birth:	BCH Medical Record Number:	
Gender: ☐ Male ☐ Female ☐ Other	Primary Language:	
Legal Guardian(s):		
Email:		
Street Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Cell Phone:	Lives with:	

REFERRAL INFORMATION

Who recommended this evaluation:		
Phone:		
Street Address:		
City:	State:	Zip:
Primary Care Physician:		
Phone:		
Street Address:		
City:	State:	Zip:

SCHOOL INFORMATION

School:	City/State:
Current Grade:	Ever repeated a grade? ☐ No ☐ Yes, grade:

Has your child ever had an initial or 3-year evaluation for an IEP or 504 plan through the school?
☐ No ☐ Yes, date of last evaluation:

Is your child scheduled to have testing at school in the next few months or next academic year?
☐ No ☐ Yes, date:

Is your child receiving special education services or accommodations at school?
☐ No ☐ Yes, describe:

MEDICAL INFORMATION

Description of medical diagnosis:

Where does your child get care for this condition?
☐ Boston Children's Hospital ☐ Other:

Past psychological/neuropsychological testing?
☐ None ☐ Yes, date: by whom:

Previously seen in the Neuropsychology Program at Boston Children's Hospital?
☐ No ☐ Yes, date:

CURRENT PROBLEMS/CONCERNS

What is the reason you are seeking assessment at this time?

Which area(s) of neuropsychological/cognitive functioning are of primary concern at this time?

- ☐ arousal/energy level/fatigue
- ☐ attention/concentration/distractibility
- ☐ learning/memory/forgetfulness
- ☐ communication
- ☐ language
- ☐ executive skills (organization/planning/problem-solving)
- ☐ visual-perceptual/spatial
- ☐ processing speed/efficiency
- ☐ fine motor/graphomotor skills
- ☐ emotional status
- ☐ adaptive functioning
- ☐ social functioning

FINANCIAL INFORMATION

Who will be financially responsible for these services?

☐**Insurance Company**

Please provide complete insurance information. You can find this on your insurance card.

Insurance company:
Plan name:
Name of subscriber:
Subscriber date of birth:
Insurance card ID#:
Member services phone #:
Provider services phone #:

☐**Self-Pay** (Payment is expected at time of check-in)

☐**Other:**

NEXT STEPS

Please contact your insurance company to determine your coverage and benefits.

Most insurance plans require prior authorization for this type of service. If they do, the Neuropsychology Program Coordinator will work with the clinicians and insurance carrier to obtain this. We will notify you prior to any scheduled appointment if your insurance denies our request for authorization.

However, even if your insurance carrier has given approval for the service, it does not necessarily mean they will cover it in full.

Depending on your insurance and coverage you may have a deductible to meet before your insurance pays anything or you may be responsible for a percentage of the cost of services. For this reason, we ask that you contact your insurance carrier to understand your coverage.

Would you like us to contact you if an appointment opens up with short notice?

☐No, thank you ☐Yes, please call me at:

Please mail or fax all psychological testing and school evaluation reports.