TNS

Triangle Neuropsychology Services Referral Form

www.triangleneuropsychology.com
Telephone: 919-384-9682 Fax: 919-384-9683

Date Referred: _____

Referred By _____ Phone: _____ Fax: _____

Referred TO: **Triangle Neuropsychology Services Phone# 919-384-9682 Fax #: 919-384-9683**

Office Locations: ☐ 3310 Croasdaile Drive, Suite 400, Durham, NC 27705

☐ 1540 Sunday Drive, Suite 200, Raleigh, NC 27607

Patient Name _____ DOB: _____ Gender: ☐ F ☐ M

Parent's Name (if patient is a minor) _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's Address: _____

Please indicate the appropriate medical reasons for the referral in the space provided below

Reason for Referral (Symptoms of Concern): Please attach dictated summary or medical records

This patient is being referred for a neuropsychological evaluation to

☐ Assist with diagnosis and management following clinical evaluation when a mental illness or neuropsychological abnormality is suspected.

☐ Provide a differential diagnosis from a range of neurological/psychological disorders that present with similar symptoms (e.g. differentiation between pseudo-dementia and depression)

☐ Determine the clinical and functional significance of brain abnormality.

☐ Delineate the specific cognitive basis of functional complaints.