



RUSK INSTITUTE of Rehabilitation Medicine

REFERRAL FOR OUTPATIENT ADULT PSYCHOLOGY FAX to the RUSK BUSINESS OFFICE (212) 263-0113

Date: _____
 Patient Name: _____
 Patient Date of Birth: _____ Patient Social Security Number: _____
 Patient Telephone Number: Contact 1: (____)____-_____
 Contact 2: (____)____-_____
 Patient Address: _____
 Primary Insurance: _____ Policy Number: _____ Insured Name: _____
 Secondary Insurance: _____ Policy Number: _____ Insured Name: _____

Prescription for (*Please select Neuro-Cognitive and/or Psychological Service/Diagnoses*):

Neuro-Cognitive Services:

____ Cognitive Evaluation *or* ____ Cognitive Evaluation and Treatment
 ____ Patient *or* ____ Patient and Family
 Relevant cognitive symptoms: _____

Diagnoses: _____ **ICD9:** _____
 ____ Brain Injury ____ Encephalopathy
 ____ Left/Right/Both CVA ____ Cognitive Disorder due to _____
 (please circle)
 ____ Other _____

Psychological Services for: _____ (Specify physical disability/condition):

____ Psychological Evaluation *or* ____ Psychological Evaluation & Treatment
 ____ Patient *or* ____ Patient and Family
 Relevant psychological symptoms: _____

Diagnoses: _____ **ICD9:** _____
 ____ Adjustment Disorder w/ Depressed Mood
 ____ Adjustment Disorder w/ Anxiety
 ____ Adjustment Disorder w/ Anxiety and Depression
 ____ Personality change due to _____
 (list injury or illness, e.g. Brain Injury)
 ____ Other _____

Previous neuropsychological evaluation? _____ If yes, date: _____

Physician's Name/Specialty: _____
 License Number: _____ UPIN: _____ NPI# _____
 Office Telephone: _____ Office Fax: _____
 Physician's Signature: _____

