CLEAR COGNITION
1800 Hollister Drive, Suite G2
Libertyville, IL 60048

Office: 847.786.5366 Fax: 847.786.5535

Referral For Neuropsychological Assessment

Patient Information

Patient's Name: _____ DOB: _____ SSN XXX-XX-_____

Responsible Party To Contact (if other than patient): _____ *Relationship*: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell: _____ Ok to leave detailed message? ☐ Yes ☐ No

Work: _____ Ok to leave detailed message? ☐ Yes ☐ No

Email: _____ Ok to leave detailed message? ☐ Yes ☐ No

Reason for referral (or ICD-10 Diagnoses if known): ☐ **R41.2** ☐ **R41.3** ☐ **R41.844** ☐ **R41.89** ☐ **Other (Specify)**_____

Order for Neuropsychological Evaluation to: ☐ ***Dr. Alia Ammar*** ☐ ***Dr. Loren Hizel*** ☐ ***Unspecified***

_____ _____

Referring Provider's Name Referring Facility

_____ _____

Referring Provider's Signature Date

Phone: _____ Fax _____

Payment Information (Please attach a copy of the front & back of card)

Primary Insurance: _____

Policy/ID#: _____ Group #: _____

Policy Holders Name _____ DOB: _____ Relationship: _____

Insurance Company Phone #: _____ Mental Health Phone #: _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy/ID#: _____ Group #: _____

Policy Holders Name _____ DOB: _____ Relationship: _____

Insurance Company Phone #: _____ Mental Health Phone #: _____

Policy Holder's Employer: _____

FAX PROGRESS NOTE AND COPY OF INSURANCE CARD (front & back)
(949) 862-8661