1 Patient Information

1 PATIENT DETAILS

Name:		Date of Service:	
DOB:		Provider:	
Age / Sex:		MRN:	
Visit Type:		Referral Source:	

CC Chief Complaint

2 PRIMARY CONCERN

Document the primary cognitive, behavioral, emotional, or functional concern prompting neuropsychological evaluation, including duration and context when available...

S Subjective

3 PATIENT-REPORTED & COLLATERAL-REPORTED CONCERNS

3a COGNITIVE SYMPTOMS

Memory loss, attention difficulty, executive dysfunction, processing speed concerns, language difficulty, visuospatial problems, or problem-solving deficits...

3b ONSET & COURSE

Timing of symptom onset, progression, stability, fluctuation, or acute change...

3c FUNCTIONAL IMPACT

Effects on work, school, driving, medication management, finances, daily activities, and independent functioning...

3d EMOTIONAL / BEHAVIORAL SYMPTOMS

Mood disturbance, anxiety, irritability, apathy, impulsivity, personality change, sleep disturbance, or behavioral dysregulation...

3e RELEVANT NEUROLOGIC / MEDICAL HISTORY

TBI, stroke, seizure disorder, neurodegenerative disease, CNS infection, sleep disorder, chronic pain, or other conditions impacting cognition...

3f EDUCATIONAL / OCCUPATIONAL HISTORY

Highest level of education, learning difficulties, special education history, employment history, and occupational functioning...

3g COLLATERAL INFORMATION

Family, caregiver, school, employer, or referring provider observations when available...

3h PERTINENT NEGATIVES

Document denial of acute neurologic decline, psychosis, suicidal ideation, homicidal ideation, or safety concerns when clinically relevant...

O Objective

4 OBSERVED & MEASURED FINDINGS

4a BEHAVIORAL OBSERVATIONS

Appearance, cooperation, effort, engagement, frustration tolerance, speech, comprehension, and response style during testing or interview...

4b MENTAL STATUS EXAMINATION

Appearance:		Behavior:	
Speech:		Mood:	
Affect:		Thought Process:	
Thought Content:		Perception:	
Orientation:		Attention / Concentration:	
Insight:		Judgment:	
Safety:			

4c NEUROPSYCHOLOGICAL TESTING / MEASURES ADMINISTERED

List standardized instruments, screening tools, rating scales, or performance validity measures administered during the encounter...

4d TEST BEHAVIOR / VALIDITY CONSIDERATIONS

Effort, cooperation, fatigue, sensory limitations, language factors, cultural/educational factors, or validity concerns that may affect interpretation...

R Results / Data Reviewed

5 CLINICALLY RELEVANT FINDINGS

5a COGNITIVE DOMAINS

Attention, working memory, processing speed, learning and memory, language, executive functioning, visuospatial skills, and motor functioning as assessed...

5b EMOTIONAL / BEHAVIORAL MEASURES

Depression, anxiety, trauma symptoms, behavioral rating scales, adaptive functioning, or caregiver-report measures...

5c RECORDS REVIEWED

Prior neuroimaging, neurology notes, psychiatric records, school records, laboratory results, or prior testing...

A Assessment

6 NEUROPSYCHOLOGICAL FORMULATION

Cognitive profile and pattern of strengths/weaknesses. Diagnostic impression or differential diagnoses. Relationship of findings to medical, neurologic, psychiatric, developmental, or psychosocial factors. Functional implications and level of support required. Risk or safety concerns, if present...

P Plan

7 RECOMMENDATIONS

7a ADDITIONAL TESTING & FEEDBACK

Additional testing or completion of evaluation if needed. Feedback session plan...

7b REFERRALS & COGNITIVE STRATEGIES

Referrals (neurology, psychiatry, therapy, SLP, OT, academic supports). Cognitive rehabilitation or compensatory strategies...

7c SAFETY RECOMMENDATIONS

Driving, medication management, financial oversight, supervision needs...

7d PATIENT / CAREGIVER EDUCATION

Education provided regarding findings, strategies, and next steps...

F Follow-Up

8 NEXT APPOINTMENT & MONITORING PLAN

Next appointment, feedback session, repeat testing interval, or monitoring plan: ______________________

TIME DOCUMENTATION & BILLING

Total Time: ____________ Testing Time: ____________ Scoring / Interpretation: ________ Report Writing: ____________

Feedback / Counseling Time: ______________________

CPT Code(s): ______________________ Basis for Billing: ______________________

Primary ICD-10 Code: ______________________ Secondary ICD-10 Code(s): ______________________

PROVIDER NAME, PHD / PSYD / MD	SPECIALTY: NEUROPSYCHOLOGY	DATE	TIME