



RUSK PEDIATRIC PSYCHOLOGY

Outpatient Referral Form

FAX to 212-263-4555

Date: _____ Patient DOB: _____

Patient Name: _____

Patient Social Security Number: _____

Telephone Number: Contact 1: (_____) _____ - _____ Contact 2: (_____) _____ - _____

Patient Address: _____

Primary Insurance: _____ Policy Number: _____ Insured Name :

Secondary Insurance: _____ Policy Number : _____ Insured Name:

(Please fill out appropriate section below: Neuropsychological services, Mental health services or both)

1) Neuropsychological Services (only codes under 290 and over 319 are covered)

Medical Diagnosis: _____ **ICD9:** _____

- | | | |
|---|------------------------|--------------------|
| _____ Unspecified Disorder of the Brain | _____ Seizure Disorder | _____ Concussion |
| _____ Cerebral Palsy | _____ Stroke | _____ Brain Injury |
| _____ Static Encephalopathy | _____ Cancer | _____ Other |

Prescription For:

_____ Neuropsychological Evaluation and Treatment (96116, 96118, 96119, 97532)

Relevant Neuropsychological Symptoms:

2) Mental Health Services directly related to a medical/neurological diagnosis.

(only codes 290-319 are covered)

Mental Health Diagnosis: _____ **ICD9:** _____

- | | | |
|------------------|---------------|------------|
| _____ Depression | _____ Anxiety | _____ PTSD |
|------------------|---------------|------------|

Prescription for:

_____ Psychological Evaluation and Treatment (90801,90802,90804, 90806,90846, 90847)

Relevant mental health symptoms:

Physician's Name (Please Print): _____

Physician's Address _____

License Number: _____ UPIN: _____ NPI# _____

Office Telephone: _____ Office Fax: _____

Physician's Signature: _____

**RUSK INSTITUTE OF REHABILITATION
HOSPITAL FOR JOINT DISEASES**

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