RUSK PEDIATRIC PSYCHOLOGY

Outpatient Referral Form

FAX to 212-263-4555

Date:_____ Patient DOB: _____
Patient Name: _____ Sex: M □ F □
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
_____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 (90791, 90832, 90834, 90837, 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 REHABILITATION
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