NYU Medical Center **RUSK INSTITUTE** of Rehabilitation Medicine

ADULT PSYCHOLOGY Outpatient Referral Form

FAX to the RUSK BUSINESS OFFICE (212) 263-0113

Date: _____

Patient Name: _____ Patient DOB: _____

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: _____

(***Please fill out appropriate section below: neuro-cognitive services, mental health services or both. Note: a diagnosis for each service area is required to obtain 3rd-party coverage)*:**

Neuro-Cognitive Services: ***(only codes under 290 and over 319 are covered)***

Diagnoses: _____ ***ICD9***: _____

____Brain Injury ____ Encephalopathy

____Left/Right/Both CVA ____Cognitive Deficit due to_____

(please circle)

____Other _____

Prescription for:

____Cognitive Evaluation *or* ____Cognitive Evaluation and Treatment

____Patient *or* ____Patient and Family

Relevant cognitive symptoms: _____

Previous neuro-cognitive evaluation? _____ If yes, date: _____

Mental Health Services for: _____(Specify physical disability/condition):

Diagnoses: _____ ***ICD9***: _____ ***(only codes 290-319are covered)***

____Adjustment Disorder w/ Depressed Mood

____Adjustment Disorder w/ Anxiety

____Adjustment Disorder w/ Anxiety and Depression

____Personality change due to _____ (note injury or illness, e.g. Brain Injury)

____Other _____

Prescription for:

____Psychological Evaluation *or* ____Psychological Evaluation & Treatment

____Patient *or* ____Patient and Family

Relevant psychological symptoms: _____

Physician's Name/Specialty ***(Please print)***:_____

Physician's Address: _____

License Number: _____ UPIN: _____ NPI# _____

Office Telephone: _____ Office Fax: _____

Physician's Signature: _____