MGH LEAP – Learning and Emotional Assessment Program
Referral for Neuropsychological Testing

Please fax to**: 617-643-6060** or email to: **LEAP@partners.org**

From: Referring physician: ________________________ Phone/Pager: __________

Staff Assistant Sending Fax: ___________________ Ext: _________________

PATIENT'S NAME: _____________________________________ **MGH MRN:** ___________
(*If patient not registered at MGH, please have them do so by calling the Registration Center @ 866-211-6588)*

DATE OF BIRTH: ___________________ **INSURANCE:** __________________________________
(Contracted with most insurances, however not contracted with CIGNA, Fallon, Network Health (effective 1/2014)

If patient is a child, please provide: **NAME OF PARENT(S):** ___________________________________

PARENT HOME TEL: __________________ **PARENT WORK/CELL TEL:** _________________

YES NO **Has this patient had previous neuropsychological testing (96118)?** *(If "yes", what is the date of service and with whom? If you have a copy of the previous report, please fax with this form or scan into LMR.)*

YES NO **Has this patient had previous psychological evaluation (90801)?** *(If "yes", what is the date of service and with whom? If you have a copy of the previous report, please fax with this form or scan into LMR.)*

YES NO **Has this patient had previous educational testing and/or receives special education services (e.g., IEP, 504 Plan, etc.)** *(If "yes", what is the date of testing or most recent IEP revaluation? If you have a copy of the report, please fax with this form or scan into LMR.)*

Please indicate your reason(s) for seeking an assessment:

__ Developmental Delays __ Attention/Executive Functioning __ Speech & Language
__ Visual-Motor Skills __ Memory __ Learning: Reading, Math, Writing
__ Social communication __ Inflexibility, routine-oriented __ Behavior/emotion regulation
__ Moody, depressed __ Anxiety, fears, OCD __ Trauma
__ History of Medical Issues (e.g., prematurity, head injury, genetic disorder, etc)
If yes, please list: ____

Please describe the clinical question(s) that you would specifically like testing to address:

Working diagnosis:

CONFIDENTIAL

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If you received this information in error, please contact the sender at contact number listed above and MGH Privacy Office at (617) 726-6360 and properly dispose of this information.