MGH LEARNING AND EMOTIONAL ASSESSMENT PROGRAM 617-643-6010

PARENT REFERRAL FOR NEUROPSYCHOLOGICAL EVALUATION

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

PATIENT'S NAME: _____ **MGH MRN:** _____

(Patient must be registered at MGH, which can be done by calling the Registration Center @ 866-211-6588)

DATE OF BIRTH: _____ **INSURANCE:** _____

(We are contracted with most insurances, however we are not contracted with CIGNA, Fallon, Network Health)

If patient is a child, please provide:

NAME OF PARENT(S): _____

PARENT HOME TEL: _____ **PARENT WORK/CELL TEL:** _____

EMAIL ADDRESS TO CONFIRM RECEIPT OF REFERRAL: _____

WHO RECOMMENDED THAT YOU CONTACT US? (Check all that apply)

- ☐ Parent/Self
- ☐ Pediatrician
- ☐ Psychologist/Psychiatrist: If yes, please provide name/institution: _____
- ☐ Medical Doctor/Specialist: If yes, please provide name/institution: _____

WHY ARE YOU SEEKING AN EVALUATION AT LEAP?

(Briefly explain your concerns about your child's mental/medical health, behavioral, or academic issues.)

Does your child have a history of any of the following? (Check all that apply)

☐ Prematurity/low birth weight	☐ Delayed motor skills
☐ Hydrocephalus	☐ Cerebral Palsy
☐ Epilepsy or Seizure Disorder	☐ Delayed language skills
☐ Early Intervention Services	☐ Special Education Services
☐ Other Chronic Medical Condition:	
☐ Genetic/chromosomal condition:	

Has your child been diagnosed with or do you currently have concerns about any of the following conditions? (Check all that apply)

☐ Attention Deficit Hyperactivity Disorder (including ADD)	☐ Autism-Spectrum Disorders, including Pervasive Developmental Disorder & Asperger's Disorder
☐ Anxiety ~Obsessive-Compulsive Disorder ~Difficulties with separation	~Post-traumatic Stress Disorder ~Specific fears or phobias
☐ Depression or mood swings	☐ Aggressive or oppositional behaviors
☐ Social Difficulties	☐ Tics or Tourette's Disorder
☐ Substance abuse	☐ Learning Disabilities Reading_____ Math_____

Is your child seeing or has your child ever seen a psychiatrist, psychologist, or therapist?
Name and Phone Number of Provider: _____
Briefly explain why and how long you have been working with this provider.

Has your child seen a neurologist or developmental pediatrician in the past?
Name and Phone Number of Provider: _____
Briefly explain why and how long you have been working with this provider.

Is your child taking any prescription medications? If so, then please list names and dosages.

Is your child currently receiving any of the following services:

- ☐ Occupational/physical therapy
- ☐ Speech and Language Therapy
- ☐ Social Skills Training
- ☐ Applied Behavior Analysis (ABA) Therapy
- ☐ Special Education Services as part of an IEP or 504

Has your child had any previous testing:

- ☐ Academic Testing (through the school or another clinic)
  - If yes, please provide dates of testing: _____
- ☐ Neuropsychological/Psychological Testing
  - If yes, please provide dates of testing: _____

Learning and Emotional Assessment Program
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