MGH Multicultural Assessment and Research Center (MARC)

Referral for Neuropsychological Evaluation

100 First Avenue, Building 39 – Suite 101, Charlestown, MA 02129
Phone: 617-643-5883 Fax: 617-643-5896

Patient's Name: DOB:	Referring Provider's Name: Email:
MGH Medical Record Number:	Referring Provider specialty:
Insurance: Policy Number:	Referring Phone: Referring Fax:
Who should we contact to schedule this appointment? Phone:	Language requested for evaluation:

1. Are you currently involved in this patient's care?
   ☐ Yes ☐ No

2. Has this patient had a neuropsychological or psychological evaluation in the past?
   ☐ Yes, When: _____ Where: _____
   ☐ No

3. What is the patient's level of education? _____

4. What is the patient's primary language? _____

5. What is the main reason for referral? Check all that apply.
   ☐Cognitive Concerns ☐ Memory Impairment
   ☐ Behavioral Changes ☐ Change/decline in cognitive function
   ☐ Baseline Neuropsychological Evaluation ☐Cognitive strengths and weaknesses
   ☐ Cognitive training (*Please note that patient should have had a neuropsychological evaluation in the past six months).
   ☐ Other: _____

6. Please describe the need for testing and any other relevant information below:
   _____
   _____
   _____
   _____
   _____

- *If the patient is not registered please have them call Mass General Registration and Referral Center at 866-211-6588.*
- *If faxing or emailing this referral form, please submit clinical notes that support the need for testing.*