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Neuropsychology  
3000 New Bern Avenue  
Raleigh NC 27610

**Neuropsychology Fax Referral**

From: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Please complete the following and attach recent office notes and any available neuroimaging (CT, MRI, etc.) reports and fax to 350-7130.**

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

DOB/Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis & ICD-9 code: \_\_\_\_\_

Referral Question(s): \_\_\_\_\_

Insurance: \_\_\_\_\_ Group number: \_\_\_\_\_

Policy / Member ID number: \_\_\_\_\_

Scheduling needs: \_\_\_\_\_

