PATIENT REFERRAL FORM **DATE:**________________________

TO: **NeuroResources**
William D. Ruwe, Psy.D., Ph.D.
Leanne Buttross, Ph.D.

FAX: **(405) 286-6004**

PATIENT INFORMATION

Patient Name: ________________________ Diagnosis: ________________
Address: ________________________ Date of Onset: ________________
________________________ Phone (home): ____________ Phone (work): ____________
SSN: ________________________ DOB: ________________
Contact Person (if not pt): ________________ Phone: ________________
Referral Physician: ________________ Phone: ________________
Date of next appt: ________________ Fax: ________________

SERVICE REQUESTED (please explain under "Referral Question")

Outpt Neuropsychology Eval (Full) ________ Outpt Neuropsychology Eval (Brief) ________
Outpt Psychological Eval ______ Outpt Psychotherapy ______ Inpatient Eval ______ Other ______

REFERRAL QUESTION: ____
____

INSURANCE INFORMATION (if available, please include copy of card(s) instead of following)

Primary Insurance: ________________ Phone: ________________
Member I.D.#: ________________ Group #: ________________
Secondary Ins.: ________________ Phone: ________________
Member I.D.#: ________________ Group #: ________________
Additional Information: ____
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PLEASE FAX THIS FORM AND ANY PERTINENT OFFICE NOTES OR MEDICAL RECORDS TO NUMBER AT TOP OF PAGE. Thanks for the referral!