WALLACE-KETTERING
Neuroscience Institute™
KETTERING HEALTH NETWORK

3533 Southern Blvd, Suite 5200
Kettering, Ohio 45429
Phone (937) 395-8043
Toll Free (844) 211-5482
Fax (937) 395-8139

Request for Consultation

Below sections MUST be completed entirely before we can schedule the patient. Thank you.

CONSULTATION REQUEST FOR: **ADULT NEUROPSYCHOLOGICAL TESTING**	**Today's Date:**

Patient Name: Last	**First**	**MI**	**Date of Birth:**	**Social Security #:**
Address:	**City:**		**State:**	**Zip:**
Preferred Phone #: (circle Home or Cell)	**Secondary Phone #: (circle Home or Cell)**		**Work #:**	
Contact Email address (if available):				

Reason for Referral/Testing:		
Please indicate who should be contacted to schedule appointment (Check one) ☐ Patient ☐☐ Designated Contact		
Contact Name:	**Relationship to Patient:**	**Phone #:**

Insurance Carrier:____

Prior Authorization #: ______________________________ (**REFERRING PHYSICIAN** must obtain authorization)

Along with your request, please fax the following information:

- **Copy of the Insurance Card – front and back**
- **Medical documentation including physician's initial evaluation and most recent visit note**
- **Previous psychological evaluations**
- **Most current labs**
- **Medication list**
- **MRI/CT/EEG reports of head or brain if done**

Referring Physician:	
Address:	**Phone:**
	Fax:
Physician NPI #:	
Physician Signature:	
Name of individual submitting the form:	**Phone:**