NYU Langone MEDICAL CENTER

AMBULATORY CARE CENTER - RUSK REHABILITATION
Psychology Department
240 East 38th Street • 17th Floor • New York, New York 10016
Telephone: 212-263-6033, ext. 45 | Email: RuskACCIntake@nyumc.org

REFERRAL FOR OUTPATIENT ADULT PSYCHOLOGY

FAX to RUSK INTAKE at (212) 263-0113

Date: _____

Patient Name: _____ Date of Birth: _____ Gender: M F
Patient Social Security Number: _____ Caregiver Name: _____
Telephone Number: Contact 1: ( ) - Contact 2: ( ) -
Patient Address: _____
Primary Insurance: _____ Policy Number: _____ Insured Name: _____
Secondary Insurance: _____ Policy Number: _____ Insured Name: _____

Please fill out all appropriate section(s) below: neuro-cognitive services, mental health services, or both.

Inclusion of clinical notes would help expedite the process. Thank you.

Neuro-cognitive Services *(ICD-10 F codes are not usually applicable for these services)*
Diagnosis*: *ICD-10 : _____ (*or choose from below)*
Traumatic Brain Injury _____ Concussion _____ Encephalopathy (type) _____
Left/Right/Bilat CVA _____ Cognitive impairment _____ Memory disorder _____

Prescription for:
Cognitive Evaluation _____ *or* Cognitive Evaluation and Treatment _____
Patient *or* Patient and Family _____
Relevant cognitive symptoms: _____
Previous neuro-cognitive evaluation? _____ If yes, date: _____

Mental Health Services for *(only ICD-10 mental health codes from F00 – F99 are applicable):*
Diagnosis*: *ICD-10: _____ (*or choose from below)*
Adjustment Disorder ____ With anxiety ____ With depression ____With mixed mood disorder _____
Personality change due to *(note injury or illness, e.g. Brain Injury)* _____
Post-Concussion Syndrome (to request mental health services for patient w/ concussion) _____

Prescription for:
Psychological Evaluation _____ *or* Psychological Evaluation and Treatment _____
Patient *or* Patient and Family _____
Relevant psychological symptoms: _____
Previous psychological evaluation? _____ If yes, date: _____

Physician Name/Specialty (***Please Print***): _____
License Number: _____ UPIN:_____ NPI#: _____
Physician Address: _____
Office Telephone: ( ) _____ - _____ Office Fax: ( ) _____ - _____
Physician's Signature: _____

NOTE: Please fax medical background information pertinent to referral along with this form