

Psychological/Neuropsychological Testing Request Form

Email to: contact@evergreenwellnesscenter.org or Fax to: 508.967.7194

Patient Name: _____

DOB: ___/___/___ **Male** **Female** **Other:** _____

Parent or *Legal* guardian (if applicable): _____

Contact Phone:(_____)_____-_____ **Contact email:** _____

Insurance Co: _____ **Member ID:** _____

2nd Insurance Co: _____ **Member ID:** _____

FOR Healthcare Providers only: Name & Company of person making referral:

Email copy of report to person making referral? YES or NO

*If YES, the email **must** be provided below (EWC is a paperless office)*

Email: _____

Current diagnostic impression (of healthcare provider):

What questions should this evaluation address? *Please be specific:*

How did you hear about Evergreen? _____