NYU Langone MEDICAL CENTER

RUSK REHABILITATION

RUSK PEDIATRIC PSYCHOLOGY Outpatient Referral Form

FAX to 212-263-4555

Date: _____ Patient DOB: _____

Patient Name: _____ Sex: M □ F □

Parent/Guardian Name (If appropriate):_____

Telephone Number: Contact 1: (_____) _____- _____ Contact 2: (_____)_____ -_____

Patient Address: _____ _____

_____ _____

Primary Insurance: _____ Policy Number:_____Insured Name:

Secondary Insurance: _____ Policy Number : _____Insured Name:

1) □ Neuropsychological Assessment (only codes under 290 and over 319 are covered)

Medical Diagnosis: _____ ICD10: _____

_____Unspecified Disorder of the Brain _____Seizure Disorder

_____Cerebral Palsy _____Stroke _____Brain Injury

_____Static Encephalopathy _____Cancer _____Other

_____Neuropsychological Evaluation (96116, 96118, 96119, 97532)

2) □ Mental Health Therapy directly related to a medical/neurological diagnosis. (only codes 290-319 are covered) ICD10:_____

Relevant mental health symptoms:

_____Depression _____Anxiety _____PTSD _____Other

_____Psychological Evaluation and Treatment (90791, 90832, 90834, 90837, 90846, 90849, 90846)

3) □ Health and Behavior Intervention

Medical Diagnosis:_____ ICD 10:_____

_____ Health and Behavior Consultation (96150, 96152, 96153, 96154, 96155)

Relevant mental health symptoms:

____Behavioral/emotional difficulties ____Biopsychosocial factors related to physical health problems ____Other:

Physician's Name (Please Print): _____

Physician's Address _____

License Number: _____ UPIN: _____ NPI#_____

Office Telephone: _____ Office Fax: _____

Physician's Signature: _____

NYU Langone Orthopedic Hospital
NYU Rusk Rehabilitation

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