WALLACE KETTERING NEUROSCIENCE INSTITUTE
3533 Southern Boulevard
Suite 5200
Kettering, Ohio 45429
Phone 937-395-8043 Fax 937-395-8139
Request for Consultation

BELOW SECTIONS MUST BE COMPLETED ENTIRELY BEFORE WE CAN SCHEDULE THE PATIENT, THANK YOU.

CONSULTATION REQUEST FOR **NEURO PSYCH TESTING Nicholas Doninger, Ph.D.** **Christopher Contardo Ph.D.**	**Today's Date:** _____

Patient Name: Last:	**First:**	**MI**	**DOB:** **SS#**
Address:	**City:**	**State**	**Zip:**
Home Phone#	**Cell Phone#**	**Work #**	
REASON FOR REFERRAL/TESTING:			
*****PLEASE INDICATE WHO SHOULD BE CONTACTED TO SCHEDULE APPOINTMENT** ☐ **Patient** ☐ **Designated Contact/Relationship** _____ **Phone #**_____			
Insurance: ***Referring Physician must obtain Authorization/Authorization #** _____ **Please Fax Copy of Insurance Card (front and back)*			

**** Along with your request, please fax the following information**

- **Medical documentation including physician's initial evaluation of patient 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 and phone number of individual submitting form:** _____

For WKNI use only: This cover sheet will be faxed back to you once an appointment has been scheduled for your patient.

Appt Date: _____ **Tine:**_____ **with Dr.** _____

Return Fax Sent/Date: _____ **By:** _____