

WALLACE KETTERING NEUROSCIENCE INSTITUTE

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Kettering, Ohio 45429

Phone 937-395-8043 Fax 937-395-8139

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

CONSULTATION REQUEST FOR: PEDIATRIC NEUROPSYCH TESTING - Julie Miller, Psy.D., ABPP	Today's Date: _____
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Patient Name: Last: _____	First: _____	MI: _____	DOB: _____
Address: _____	City: _____	State _____	Childs Age: _____
Zip: _____			

Must have Parent/Guardian Information:

Name: _____ **Phone #'s Home:** _____

Address: _____ **Cell:** _____

_____ **Work:** _____

Relationship to patient: _____

Insurance:
Please Fax Copy of Insurance Card (front and back)

REFERRING PHYSICIAN: _____

ADDRESS: _____ **PHONE #:** _____

_____ **FAX #:** _____

PHYSICIAN SIGNATURE: _____

Name and phone number of individual submitting form: _____

Appointment Type Requested (Please Check): **PRIORITY** **ROUTINE**

ICD-9 or DSM-IV DIAGNOSIS CODE(S): _____

Reason for referral/Referral question: _____

Along with your request, please fax the following information:

- **Medical documentation (i.e., physician's initial evaluation of patient and most recent office/visit note)**
- **Any supporting medical records (i.e., results of MRI/CT/EEG/Genetic testing/Labs, etc.)**
- **Available school records**

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

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

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