McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Neuropsychological and Psychological Testing Service
Clinician Referral Form

Please download this form before filling it out.
Submit completed form and additional clinical information via fax to:
617.855.3246 Attn: Neuropsychology

Patient Name: _____

DOB: _____ Phone: _____

Address: _____

Please indicate type of testing requested, by checking the applicable option(s):

☐ Neuropsychological (e.g. cognitive, IQ) ☐ Psychodiagnostic (e.g., mood, psychosis, personality)

Reason for referral:

_____

_____

_____

Symptoms / behavioral observations / reports:

_____

_____

_____

_____

Specific diagnostic questions or rule-outs:

_____

_____

Current treatment:

_____

_____

Prior evaluations (if any, please list: type of testing, date(s) and findings/results)

_____

_____

Name of Referring Clinician: _____ Clinician Phone: _____

For more information or with any questions, call 617.855.3183.