Catherine Wood, Ph.D.
Clinical Neuropsychologist

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Provider Referral Form

Please fax this completed form along with clinical documentation to 877-860-2686. Alternatively, you can send the referral packet by secure email to office@woodphd.com.

Required Clinical Documentation Checklist (Check all that apply):

- ☐ Recent Progress Notes / Clinic Notes
- ☐ Neurodiagnostics (CT / MRI, PET, DaT, EEG, lumbar puncture, genetic testing, etc.)
- ☐ Relevant Lab Work
- ☐ Front / Back of Insurance Cards

1. Patient Information

Full Name: _____ DOB: _____
Address: _____
Race / Ethnicity: _____ Sex / Gender: _____
Cell Phone: _____ Home Phone: _____
Caregiver / Emergency Contact Name & Phone Number (If Applicable): _____
_____

2. Insurance Information

Primary Insurance Carrier: _____
Policy ID #: _____ Group #: _____
Policy Holder Name: _____ Policy Holder DOB: _____

Secondary Insurance Carrier: _____
Policy ID #: _____ Group #: _____
Policy Holder Name: _____ Policy Holder DOB: _____

3. Referring Provider Information

Provider Name: _____ NPI #: _____
Practice Name / Address: _____
Phone: _____ Fax: _____
Form Completed By: _____

4. Clinical Reason for Referral

Primary Diagnosis / Provisional ICD-10 Code: _____
Specific Evaluation Question(s) / Recommendations Requested:
_____
_____

Thank you for consulting our practice. We look forward to partnering with you in your patient's care.

For Office Use Only:
Referral Received: _____ Appointment Date/Time: _____