



AMBULATORY CARE CENTER - RUSK REHABILITATION
Psychology Department

240 East 38th Street • 17th Floor • New York, New York 10016
Telephone: 212-263-6033, ext. 45 | Email: RuskACCIntake@nyumc.org

REFERRAL FOR OUTPATIENT ADULT PSYCHOLOGY
FAX to RUSK INTAKE at (212) 263-0113

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M F
Patient Social Security Number: \_\_\_\_\_ Caregiver Name: \_\_\_\_\_
Telephone Number: Contact 1: ( ) - Contact 2: ( ) -
Patient Address: \_\_\_\_\_
Primary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Insured Name: \_\_\_\_\_
Secondary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Please fill out all appropriate section(s) below: neuro-cognitive services, mental health services, or both.
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Inclusion of clinical notes would help expedite the process. Thank you.

Neuro-cognitive Services (ICD-10 F codes are not usually applicable for these services)

Diagnosis: ICD-10 : \_\_\_\_\_ (or choose from below)
Traumatic Brain Injury \_\_\_\_\_ Concussion \_\_\_\_\_ Encephalopathy (type) \_\_\_\_\_
Left/Right/Bilat CVA \_\_\_\_\_ Cognitive impairment \_\_\_\_\_ Memory disorder \_\_\_\_\_

Prescription for:

Cognitive Evaluation \_\_\_\_\_ or Cognitive Evaluation and Treatment \_\_\_\_\_
Patient or Patient and Family \_\_\_\_\_
Relevant cognitive symptoms: \_\_\_\_\_
Previous neuro-cognitive evaluation? \_\_\_\_\_ If yes, date: \_\_\_\_\_
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Mental Health Services for (only ICD-10 mental health codes from F00 – F99 are applicable):

Diagnosis: ICD-10: \_\_\_\_\_ (or choose from below)
Adjustment Disorder \_\_\_ With anxiety \_\_\_ With depression \_\_\_ With mixed mood disorder \_\_\_
Personality change due to (note injury or illness, e.g. Brain Injury) \_\_\_\_\_
Post-Concussion Syndrome (to request mental health services for patient w/ concussion) \_\_\_\_\_

Prescription for:

Psychological Evaluation \_\_\_\_\_ or Psychological Evaluation and Treatment \_\_\_\_\_
Patient or Patient and Family \_\_\_\_\_
Relevant psychological symptoms: \_\_\_\_\_
Previous psychological evaluation? \_\_\_\_\_ If yes, date: \_\_\_\_\_
.....

Physician Name/Specialty (Please Print): \_\_\_\_\_
License Number: \_\_\_\_\_ UPIN: \_\_\_\_\_ NPI#: \_\_\_\_\_
Physician Address: \_\_\_\_\_
Office Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Office Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_
Physician's Signature: \_\_\_\_\_

NOTE: Please fax medical background information pertinent to referral along with this form