Tailored Brain Health
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Greensboro, NC 27408

Referral Form

Potential Client referrals will be contacted within 48 hours of referral. All services and related costs will be discussed with the potential client prior to starting services.
All information contained in this document is confidential.

Provider/Office Name:_____

Referral Phone:_____ Referral Fax:_____

Date:_____

Patient/Client Name:_____

Patient DOB: _____Responsible Party:_____

Contact Phone Number:_____

Contact Email:_____

Contact Address:_____

Preferred Method of Contact:_____

Patient insurance: ___Medicare (likely covered)

____Other insurance/non-Medicare (not covered)

Recommended Service(s):
Neuropsychology:
☐ Neuropsychological Assessment
☐ Consultation and Care Planning
☐ Caregiver support → Name of Caregiver _____ Caregiver Phone:_____
Clinical psychology:
☐ Psychological Assessment
☐ Psychotherapy

Differential/Rule-Out Diagnoses:_____
Reason for Referral:
_____
_____
_____

Thank you for your referral. Please Fax this Form to (336) 542-1888 or email info@tailoredbrainhealth.com