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Information is Power[™]

Board-Certified Clinical Neuropsychology

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Please provide the following records (when applicable and/or available):

1. First Responder's Report (i.e. EMT, police, ambulance).
2. Admission/Discharge summaries from the hospital (Emergency Room, Intensive Care Unit, Rehabilitation Unit). Note: billing records are not necessary.
3. Neuroimaging (i.e. CT, MRI, fMRI – any imaging done of the brain/head) Please provide the actual images on CD and Radiology Report.
4. Any previous neuropsychological, psychological, and/or psychiatric evaluation reports – including inpatient hospitalization records, if applicable.
5. Notes/summaries/reports for any pre-existing symptom history, diagnoses, or treatment pertaining to the brain, cognition, and/or mental health (e.g. neurology, mental status exams, speech-language/cognitive therapy, psychological counseling, breathing/respiratory/lung function, substance abuse).
6. Academic records (i.e. high school/college transcripts) from before the accident/illness. Transcripts from after the accident/illness onset are requested as well.
7. Employment history and/or evaluation records.
8. Collateral Contact information (phone numbers of 2-3 close family members or friends who knew the patient before and after the injury/illness onset) who would be willing to speak with me regarding the patient's history and current functioning.

Please note, I prefer scanned records on CD or via other internet/electronic medical records sharing system (e.g. Dropbox). An index of the medical records submitted to my office is required to ensure that I can accurately track all records provided for review over the course of the case. Also, please label each document appropriately when providing records electronically. The indexing and labeling of records cuts down on the amount of time we have to bill for the records review aspect of the evaluation.

****It is critical that all relevant records from a patient's history be provided to me two weeks prior to the scheduled evaluation to avoid appointment cancellation. Please be thorough in collecting and providing records. It is expected that the referring party or client provide a complete set of records for review, as historical information is critical in formulating opinions and offering a differential diagnosis. Please not that the opinions, impressions, conclusions, and recommendations stated in my reports are subject to modification or amendment, should additional records, clinical data, or other information become available to warrant such change.***