Please return via fax to (916) 703-0350

Date:

Dear MIND Institute clinics,

I am requesting a referral to the **22q Healthy Minds Clinic** for my patient

Name: ________________________________ DOB:____________ Gender: ☐ Male ☐ Female
for evaluation of (check all that apply):

- ☐ 22q11.2DS/Velocardiofacial Syndrome (Q93.81)

AND

- ☐ Anxiety State, unspecified (F41.1)
- ☐ Attention or concentration deficit (R41.840)
- ☐ Autism Spectrum Disorder (F84.0)
- ☐ Cognitive Communication Deficit (R41.841)
- ☐ Delayed Milestones (R62.0) Details:_______________________________
- ☐ Dyslexia and alexia (R48.0)
- ☐ Memory disturbance (R41.3)
- ☐ Mild neurocognitive disorder due to another medical condition (G31.84)
- ☐ Symbolic Dysfunction, e.g. dyscalculia/math disability (R48.9)
- ☐ Visual-spatial deficit (R41.842)
- ☐ Other: _________________________ ICD code:__________________
- ☐ Other: _________________________ ICD code:__________________
- ☐ Other: _________________________ ICD code:__________________
- ☐ Other: _________________________ ICD code:__________________

The CPT codes required for consult/evaluation are: 96112, 96113, 96116, 96121, 99205, 99354, 99367, 96132, 96133, 96136, 99366.

Current Medications: ____
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Other comments/questions:____
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____
____

Insurance Company/Policy # ____
Subscriber Name and DOB ____
Parent/Guardian Name____
Patient Mailing Address _____________________ State_____ Zip code______
Home Telephone ( ) _____- __________ Cell phone ( ) _____-_________
Email address ____

PCP name:____
Office contact:_____________________________________
Address:____
Telephone:____