West TN Neuroscience & Spine
700 West Forest Ave, 2nd floor, Jackson, TN 38301
Phone: 731-541-9490 Fax: 731-541-9486

Neuropsychological Evaluation Appointments

Thank you for choosing Dr. Woon for your Neuropsychological Evaluation. This evaluation takes 2 days, which are detailed below. A feedback session is optional and can be scheduled while you are in office on Day 2 for your testing visit.

Day 1: Initial virtual visit/interview

- At least 15 minutes prior to the scheduled appointment time, go my MyChart where you can find a web link to connect to video conference.
- A family member/trusted friend is strongly encouraged to join so they can provide additional information.
- Discuss relevant background and medical history with Dr. Woon.
- The visit may take approximately 60 minutes.

Day 2: Neuropsychological testing office visit

- Bring:
    - Eyeglasses and/or reading glasses
    - Hearing aids (if prescribed)
    - Medication(s) you may normally take during this time
    - A light jacket, bottle of water and/or snack (all optional)
- Show up at least 20 minutes early to complete additional paperwork.
- Please eat before coming and do not wear any perfume/cologne.
- Testing may take 1 to 2 hours with short breaks.
- Turn cellphone completely off (avoid using the "silent" mode).
- Take neuropsychological tests 1:1 with Dr. Woon or his assistant/psychometrist.
- Testing involves:
    - Q&A, paper and pencil, computer, blocks, puzzles
    - Completion of mood measures

Day 3: Follow-up virtual visit (optional)

- At least 15 minutes prior to the scheduled appointment time, go my MyChart where you can find a web link to connect to video conference.
- Discuss test results and treatment plans.
- Answer your questions.
- A family member/friend is encouraged to join this appointment.

For questions and scheduling please contact Christina at: 731-541-9509 or email @ Christina.Ingram@wth.org.

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Informed Consent for Telehealth Services

Telehealth is an innovative technology that allows healthcare providers to provide safe, effective, and convenient care through the use of technology. As with any healthcare service, they are risks and possible limitations associated with the use of telehealth, including:

- equipment failure,
- poor image resolution,
- poor audio quality, and
- information security issues/potential risks to confidentiality.

In order to reduce these risks, services will be provided via secure, alive, face-to-face video technology and the appointment will not be recorded by you or West Tennessee Medical Group. Poor image resolution or audio quality can interfere with the provider's ability to conduct a telehealth services. If you consent to receive telehealth services, it may still be determined that you need to come into the clinic for a complete assessment of symptoms.

It is possible there may be a sudden and unpredictable disruption in the telehealth connection. We will obtain your phone number at the beginning of the appointment and will call you to reestablish communication if there is a disruption in the telehealth connection.

If an emergency develops and you require crisis intervention services you agree to call the 24-hour Crisis Line (800-372-0693), go to the Emergency Room of your local hospital, or call 911 and ask to be taken to the hospital.

By signing below, I acknowledge that I have read and understand the information above. My provider has told me about the risks and benefits of receiving telehealth services, and about other choices I can make, including the risks and benefits of those. I understand that this is a new service and unexpected complications may arise. I have had the chance to ask questions and have them answered. I accepted the risks and eye voluntarily consent to the services.

Patient's signature: _____ Patient date of birth: _____ Date: _____

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RECORD OF INDEPENDENT LIVING

(*TO BE COMPLETED BY A FAMILY MEMBER OR CLOSE FRIEND*)

Patient's Name:_____ Date:_____

Form completed by:_____ Relationship to Patient:_____

Does the patient live with you? (Please Circle) **Yes** **No**

How often do you see him / her: (Please circle):
a) Daily
b) Several times a week
c) Once a week
d) Less than once a week

The patient live in: (please circle)
a) House
b) Apartment / Townhouse / Condo
c) Assisted Living Community
d) Nursing Home

If others are living in the patient's home, please circle the relationship(s) to the patient:

Spouse Daughter Son Sister Brother Friend Grandchild Other: _____

In the place where the patient is living, is he/she getting:
a) No assistance
b) Occasional assistance
c) Daily assistance
d) Around the clock supervision

Do you feel safe when the patient is driving? (Please circle) **Yes** **No** **Doesn't Drive**

Does the patient get lost when driving? (Please circle) **Yes** **No** **Doesn't Drive**

In the last 5 years, has the patient had: (Please circle)
a) Car Accidents **Yes** **No**
b) Traffic Tickets **Yes** **No**

TO BE COMPLETED BY A FAMILY MEMBER OR CLOSE FRIEND

Activities. How much assistance is currently required to perform each of the activities described below?

Instructions: For each activity, circle the number which best describes how the patient accomplishes the task. If you don't know, circle the column marked d/k. If the activity is not applicable, circle the column marked N/A.

	Does not need help, performs at the level as before illness	Has trouble but can do alone	Needs assistance	No longer does it; cannot perform task	Don't know; unable to evaluate	**Not Applicable; has never done in the past**
Eating/Feeding Self	0	1	2	3	d/k	N/A
Washing & Grooming	0	1	2	3	d/k	N/A
Using toilet	0	1	2	3	d/k	N/A
Getting dressed	0	1	2	3	d/k	N/A
Preparing food	0	1	2	3	d/k	N/A
Household upkeep, interior & exterior	0	1	2	3	d/k	N/A
Using the telephone	0	1	2	3	d/k	N/A
Operating appliances	0	1	2	3	d/k	N/A
Responsibility for personal belongings & aids	0	1	2	3	d/k	N/A
Managing Medications	0	1	2	3	d/k	N/A
Mobility-home, neighborhood	0	1	2	3	d/k	N/A
Using public transportation	0	1	2	3	d/k	N/A
Driving	0	1	2	3	d/k	N/A
Shopping & handling cash	0	1	2	3	d/k	N/A
Managing finances (bill paying, checkbook, investments)	0	1	2	3	d/k	N/A
Hobbies	0	1	2	3	d/k	N/A
Socializing with family/friends	0	1	2	3	d/k	N/A
Occupation	0	1	2	3	d/k	N/A
Function outside of familiar environment	0	1	2	3	d/k	N/A

TO BE COMPLETED BY A FAMILY MEMBER OR CLOSE FRIEND

Communication: Have there been any changes in the patient's ability to communicate?

Instructions: Mark the way in which each category is performed. An example is given. If you don't know, circle the column marked d/k. If the activity is not applicable, circle the column marked N/A.

	Does not need help, performs at the same level as before illness	**Has trouble but does not need help**	**Has trouble; needs assistance**	**No longer does it or has great difficulty**	**Don't Know**	**Not Applicable**
Talking	0	1	2	3	d/k	N/A
Understanding	0	1	2	3	d/k	N/A
Writing	0	1	2	3	d/k	N/A
Reading	0	1	2	3	d/k	N/A

12. Additional Comments:

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Neuropsychology Medical History Form

TO BE COMPLETED BY A PATIENT, FAMILY MEMBER AND/OR CLOSE FRIEND

Patient's Name:_____ Today's Date:_____ Date of Birth:_____

Occupation:_____ Working now?:_____ Education level (years):_____

Please answer the following questions about your current symptoms and medical history. We realize that you may have already provided some of this information to other doctors; however, it is important that you answer all the questions below. Thank you.

DO YOU HAVE PROBLEMS WITH:

	NO	YES	IF YES, HOW LONG
Attention / Concentration			
Memory for recent information (e.g., short term memory)			
Memory for events that have happened a long time ago			
Finding your way around familiar places			
Driving ability / safety / judgment (other than finding your way)			
Thinking of words you want to say during conversation			
Speech production (slurring or mispronouncing words)			
Understanding what people say (not due to exclusively hearing problems)			
Understanding things you read			
Doing math (e.g., balancing check book, making change)			

DO YOU HAVE PROBLEMS WITH:

	NO	YES	IF YES, HOW LONG
Dizziness			
Difficulty walking			
Difficulty with balance			
Have you fallen recently?			
If yes, How many falls in the last 6 months?			
Tremors or Shaking			
If both sides are affected, which is worse (circle one)	Right	Left	Equal
Difficulty writing			

HAVE YOU HAD ANY OF THE FOLLOWING?

	NO	YES	WHEN?
Coronary Artery Disease			
Atrial Fibrillation			
Pulmonary Disease (COPD)			
Heart Attack			
Pacemaker			
Open Heart Surgery			
Angioplasty			
Other Health Disease			

DO YOU HAVE?

	NO	YES (Well controlled)	YES (Not well controlled)	BORDERLINE
High Blood Pressure				
Diabetes				
Hypoglycemia				
Thyroid Problems				
High Cholesterol				
Migraines				
Chronic Pain				
Chronic Fatigue				

PLEASE ANSWER THE FOLLOWING:

	NO	YES	When?
Have you ever had cancer?			
If yes, treatment received?			
Have you ever suffered a head injury in which you sustained a concussion or were rendered unconscious?			
Have you ever had a stroke?			
Have you ever had a brain infection, such as meningitis or encephalitis?			
Have you ever had a seizure / convulsion / epilepsy?			

PLEASE LIST ANY MAJOR SURGICAL PROCEDURES: **DATE(S)**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE LIST ANY OTHER HOSPITALIZATIONS: **DATE(S)**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING:

	NO	YES	WHEN DIAGNOSED?
Depression			
Anxiety			
Bipolar Disorder (Manic Depression)			
Schizophrenia			
Other:			

Have you noticed any recent change in your mood? (Please circle) **NO** **YES**

If yes, how long?_____

If yes, circle all mood changes that apply:

Depressed / Down Anxious Irritable Angry

Elated Agitated Hyperactive Apathetic / Indifferent

Other (please describe) _____

Do you ever see things that other people say they cannot see? **No** **Yes**

If yes, how long?_____

If yes, please describe:_____

Do you ever hear things that other people say they cannot hear? **No** **Yes**

If yes, how long?_____

If yes, please describe:_____

HAVE YOU HAD ANY PROBLEMS / CHANGES IN YOUR:

	NO	**YES** (INCREASED)	**YES** (DECREASED)	**If YES, HOW LONG?**
Appetite				
Sleep				

Do you act out your dreams (e.g., move your arms or legs) while sleeping? (Please circle) **NO** **YES**

If yes, how long?_____

If yes, please describe:_____

Do you snore? (Please circle) **NO** **YES**

If yes, how long?_____

Please estimate how much alcohol you typically consume in a week?

Glasses of wine_____ Beers_____ Cocktails_____

Was there ever a time when you consistently drank more than this amount for at least 6 months? **NO** **YES**

Did your use of alcohol ever lead to problems with (circle all that apply):

Health Relationships Work/School Legal None

Have you ever been addicted to or abused prescription medications or other substances? **NO** **YES**

If yes, please list: _____

Do you currently use tobacco products? **NO** **YES**

If yes, how much? _____

Have you ever used tobacco products? **NO** **YES**

If yes, how long?_____

FAMILY HISTORY:

Did any of your blood relatives have memory problems as they got older, beyond what you expect for their age? (Please circle) **NO YES**

If yes, please indicate who:	Approximate age when his/her memory problems began
MOTHER	_____
FATHER	_____
SISTER	_____
BROTHER	_____

Please list any other relatives who demonstrated memory problems (maternal uncle, paternal grandfather, etc.)

_____ _____

_____ _____

Please indicate if any of your blood relatives have been diagnosed with: (Circle all that apply)

Alzheimer's / dementia:	Mother	Father	Sister	Brother	Other
Parkinson's Disease:	Mother	Father	Sister	Brother	Other
Cerebrovascular: (stroke, aneurysm, TIA, etc.)	Mother	Father	Sister	Brother	Other
Epilepsy:	Mother	Father	Sister	Brother	Other
Other Neurologic Disease:	Mother	Father	Sister	Brother	Other
Heart Disease:	Mother	Father	Sister	Brother	Other
Depression:	Mother	Father	Sister	Brother	Other
ADHD:	Mother	Father	Sister	Brother	Other
Bipolar:	Mother	Father	Sister	Brother	Other
Other Psychiatric:	Mother	Father	Sister	Brother	Other

Please list the medications that you are currently taking:	Reason

Additional notes to the Neuropsychologist you need to add?