Neuropsychological Evaluations and Reports

REFERRAL QUESTIONS

Neuropsychological evaluations are often initiated through referral from a professional person or an agency. A wide variety of referral questions of varying relevance and specificity may be encountered. The referral may describe complaints and behavioral observations that prompted the referral. It may contain a brief history and an explicit statement of the purpose of the referral. Referrals are commonly made to: (1) clarify diagnostic issues; (2) assess cognitive and/or emotional strengths and weaknesses for placement in a rehabilitation program (Alfano & Finlayson, 1987); (3) determine limitations on and supports needed for community living, school, and work; and (4) determine the existence, extent, and etiology of brain injury as evidence in forensic cases (Walsh, 1991). Referral questions may be as cryptic and obscure as "evaluate for organicity" or "neuropsychological consultation." Consulting the referral source often helps to clarify the referral question.

Inappropriate referrals are sometimes received. Again, consultation with the referral source is recommended. As the field of clinical neuropsychology matures, indications for referral for neuropsychological evaluation will be made more specific. For example, Franklin et al. (1990) have suggested specific criteria for referral of patients with multiple sclerosis.

NEUROPSYCHOLOGICAL EVALUATION

According to Hamsher (1990, p. 266), it is essential "to keep one's eye keenly fixed on the referral question." The same test result may have to be interpreted differently in different circumstances. Neuropsychologists work in a wide variety of clinical settings with great variability in referral questions and situational parameters. The practitioner should have a variety of assessment strategies and instruments in his or her repertoire. For example, the HRNB is not likely to be appropriate for an agitated head-injury patient. A brief mental status examination would generally not provide a sufficient evaluation of a testable patient for return to work. No one strategy or set of tests is appropriate in all circumstances.

If the practitioner is using a flexible battery approach and if circumstances allow, the battery should assess all basic areas of cognitive functioning—areas of functioning dependent on the brain. These areas include orientation, attention, memory, intelligence, communication, visual–spatial ability, sensory functioning, motor functioning, executive functioning, and
personality. The battery should include tests that relate to the brain generally as well as tests that relate to specific cortical areas (Reitan, 1988). Berent (1991) has suggested that tests be selected on the basis of: (1) their capacity to generate data that will answer the referral question, (2) their psychometric merits, (3) their conventional acceptance and use, and (4) the training of the individual administering the tests. The tests discussed in Part III of this book are organized according to cognitive or functional area to assist in flexible battery development.

If a diagnosis is unknown or testing is being done solely to evaluate cognitive functioning, Part III may be consulted for a listing of tests that assess specific areas of cognitive functioning. The test description includes information about modalities in which the test may be administered and in which the patient’s responses are to be made. This information can assist the examiner in tailoring the examination for patients with impairments in sensory, motor, or cognitive functioning. Information on localization in Part III and comparison with expected results of testing in Part VI may assist in diagnosis.

If a neurological disorder is suspected, the practitioner can consult Part VI for background information, expected neuropsychological test results, and probable areas of cognitive impairment. This information can assist the examiner in selecting a collection of tests that can best assess the disorder. Part III may be consulted for information on any of the selected tests. If the diagnosis is supported, Part VI may again be consulted for suggestions for treatment recommendations for inclusion in a neuropsychological report.

If the practitioner is using a standard battery and a deficit is noted, it may be useful to further define the deficit by adding tests that assess that area of functioning in more detail. Part III may provide suggestions for these additional tests. As noted above, the profile of cognitive functioning can be compared to that expected for a given disorder as outlined in Part VI.

Part IV may be of assistance in making inferences from test results to activities of daily living, driving, academics, and work.

The practitioner may refer to Part V for a listing of possible therapeutic modalities.

### NEUROPSYCHOLOGICAL REPORT

Report-writing styles vary greatly with practitioner, referral question, and setting. In some settings, a brief one- or two-page report summarizing findings and recommendations may be preferred to allow for expeditious communication. At the other extreme, a forensic evaluation may necessitate a lengthy, detailed description of all interview and test results. Experience and feedback from referral sources can assist the practitioner in tailoring his or her reports to be accurate and useful.

#### Identifying Information

Name, birth date, address, and other identifying information is recorded.

#### Reason for Referral

The referral source and question are briefly stated. It is important to clarify the referral question as much as possible, since this question will suggest the form the evaluation will take (e.g., comprehensiveness and relevancy of specific tests, issues to be explored in interview).