LifeDimensions Neuropsychological Services, Inc.
(Formerly Lifespan Services, Inc.)
250 Pond Street
Braintree, MA 02185
Phone: 781-348 2258 Fax: 781-348-2132

Dear Parent:

Please complete and return **as soon as possible** to process authorization to your insurance. Send the parent questionnaire and all records. Your appointment will not be processed without return of this information. Thank you!

Please do not send originals. We cannot be responsible for them.

(Check)

_____ (1) Parent questionnaire

_____ (2) Copy of current IEP (Individual Education Plan)

_____ (3) Copy of current report card.

_____ (4) Copies of recent school evaluations.

_____ (5) Any pertinent medical information (hospitals, clinics, etc.) including speech and language, occupational, or physical therapy assessments/discharge summaries.

_____ (6) **Please be sure that we have appropriate documentation if the patient has any D.S.S. involvement or foster care/guardianship issues. This documentation is required for registration on the day of the evaluation.**

THANK YOU!

Please mail information to the address below:

LifeDimensions Neuropsychological Services, Inc.
250 Pond Street
Braintree, MA 02184
781-348-2258

DEVELOPMENTAL NEUROPSYCHOLOGY PARENT QUESTIONNAIRE

LifeDimensions Neuropsychological Services, Inc.

250 Pond Street
Braintree, MA 02185
Phone (781) 348-2258 Fax (781) 348-2132

CONFIDENTIAL
(To be filled out by parent or guardian.)

Name of child : _____ MR#: _____
Today's Date: _____ Date of Birth: _____ Date of Eval: _____
Father: _____ Age: _____ Education: _____
Employment: _____ Business Phone: _____
Mother: _____ Age: _____ Education: _____
Employment: _____ Business Phone: _____
Legal guardian: _____ Phone: _____

Who referred you for testing? Name: _____
Address: _____ Phone: _____
Reason: _____

What are your primary concerns about your child? _____
_____
_____
_____

When did you first notice these concerns? _____
What makes these problems better? _____
What makes these problems worse? _____
Have you noticed any recent changes in behavior? _____

Has your child ever been in trouble with the law or had disciplinary problems at school?
_____
_____

Has your child ever been referred for protective services or to other agencies for services?
_____
_____

Is this child? biological _____ adopted _____ fostered _____
Does child live with both biological parents? _____ If not, what are family's living circumstances? _____
_____
Any significant stress or transition in family (recent or ongoing)? _____
If yes, describe _____
_____
_____

What is the dominant language spoken at home? _____
Other languages spoken in home? _____
What language does the child speak with parents ? _____ friends? _____

Are there any cultural or ethnic variables that you think the examiner should know about?

_____
_____

List the names & ages of all who live in the home:

Name	Relationship	Age	Highest Grade	or Learning problems?(please specify)

Biological Extended Family

Do any extended family members (grandparents, aunts, uncles, cousins) suffer from a problem with (please circle): Inattentiveness or hyperactivity; seizures; psychological, emotional, or personality disorder; migraines; learning problems; alcoholism or substance abuse; developmental disability; genetic disorders; neurological condition or any other illness? If so, please list relationship to child, disorder, and any treatment received.

Mother's Side	Father's Side

Pregnancy History - Mother

While you were pregnant with this child were you under a doctor's care? Yes _____ No _____
Mother's age at time of birth _____ Father's age at time of birth _____
Check if the following occurred during this pregnancy (give details if possible):

anemia _____ elevated blood pressure _____
toxemia _____ swollen ankles _____
kidney disease _____ heart disease _____
bleeding _____ illness or infection _____
vomiting _____ injury _____
emotional problems _____ medication w/pregnancy _____
alcohol, tobacco, or recreational drug use _____
threatened miscarriage or early contractions _____
other complications _____

Birth History

How long was labor?_____Medication? Yes ___ No___ If so, what Kind?_____
Did you have natural childbirth? Yes ___ No ___ Full term? Yes___ No__weeks early_____
Was labor induced? Yes_____ No_____ Was induced labor planned? Yes_____ No _____
Was this a breech (feet first) delivery? Yes___ No___ Did you have a Cesarean? _____
Was delivery unusual in any way? _____ If so, in what way? _____
_____

Baby's birth weight _____ Height _____ APGAR scores _____
Was the baby premature? Yes _____ No _____ If yes, how much?_____
Was the baby in an incubator? Yes _____ No _____ Intensive Care? Yes _____ No _____

Did this baby have: breathing problems? Yes _____ No _____ Don't know _____
cord around neck? Yes _____ No _____ Don't know _____
Did this baby cry quickly? Yes _____ No _____ Don't know _____
Was the baby's color normal? Yes____ No ____ Blue? ____ Jaundice? ____ Don't know ____
Was oxygen used for the baby? Yes _____ No ____ Not sure _____ How long? _____

Did the baby go home with you from the hospital? Yes ____ No ____ How Long after? _____
Was the baby normally active? _____ Describe _____

Any nursing or feeding problems (Colic, vomiting, sucking problems, swallowing problems)?
_____
Defects / illnesses noted at birth or shortly after: _____
_____

At What Age Did Your Child:

Activity	Age	Activity	Age	Activity	Age
Smile		Use full sentences		Dressed self	
Crawl		Out of diapers		Tied shoelaces	
Sit unsupported		Bowel trained		Learn colors	
Stand alone		Slept dry at night		Learn to count	
Walk		Drank from cup		Learn alphabet	
Speak first words		Ate solids		Read words	
Speak short phrases		Held toys		Read sentences	

Compared to your other children, was this child's development (circle one): faster slower about the same? Comments: _____
_____

Do you consider your child's speech and language development similar to other children's?
Yes _____ No _____ If no, please explain? _____

Any period of failure to grow or unusual growth? _____

Describe any problems with awkwardness or clumsiness: _____

_____

Describe any problems in sitting still or paying attention: _____

_____

Any other comments/concerns: _____

_____

_____

Medical History of Child

Check if your child has had:

Problem	Dates	Problem	Dates
Allergies		Ear Infections	
Allergies to medications		Hearing problems	
Measles/Mumps		Vision problems	
Chicken Pox		Sleeping problems	
Meningitis		Physical disabilities	
Encephalitis		Diabetes	
High Fever		Asthma	
Headaches		Suicide attempts	
Seizures		Substance abuse	
Injuries to Head		HIV	
Loss of Consciousness		AIDS	
Abdominal pain		Vomiting	

Hospitalizations: _____
Operations: _____
Other Illnesses/Injuries: _____

When did the child last have a: Physical examination _____Vision: _____Hearing:_____
How is your child's current health? Any recent Illnesses? _____
Are immunizations up to date? Yes: _____ No: _____ Date of last shots: _____

Is the child taking any form of medication? _____ If yes, what kind and the reason:

_____

Who prescribes the medication? _____
Previous Medications & dates: _____

Name of Pediatrician or Physician(if different from referral)_____
Mailing Address: _____
Phone/ Fax: _____

Have there been previous Psychological, Psychiatric, Neurological, CT, MRI, or EEG (please circle) Evaluations? _____ Dates: _____

***** **If yes, Please provide copies of all evaluations.** *****

Current Behavior:

Do you consider your child's activity & energy level to be: Low ____ Average ____ High _____
As compared with other children of the same age, do you think your child's general development is: Below Average _____ Average _____ Above Average _____
Describe child's appetite and eating habits at present: _____

_____

Does this child have any sleeping difficulties? _____
Does the child go to bed at the same time each night? _____
Does the child fall asleep in his/her own bed? _____
Does the child fall asleep in parent or sibling's bed? _____
Does the child need parent in the room to fall asleep? _____
Does the child struggle at bedtime? _____
Does the child fall asleep within 20 minutes after going to bed? _____
Does the child sleep too little or the right amount? _____
Does the child sleep about the same amount each day? _____
Does the child need parent in the room to fall asleep? _____
Is the child afraid of the dark? _____
Is the child afraid to sleep alone? _____
Does the child have difficulty sleeping away from home? _____
Does the child move to someone else's bed during the night (i.e. parent, sibling, etc)? _____
Does the child wake during the night? _____ How often? _____
Does the child wet the bed during the night? _____
Does the child talk during sleep? _____ Sleepwalk? _____
Is the child restless and moves a lot during sleep? _____
Does the child grind his/her teeth during sleep? _____
Does the child ever awaken during the night screaming, sweating, and inconsolable? _____
Does the child ever awaken alarmed by a frightening dream? _____
Does the child snore loudly? _____
Does the child seem to stop breathing during sleep? _____
Does the child wake up by himself/herself? _____
Does an adult or sibling wake up the child? _____
Does the child wake up in a regular mood? _____
Does the child have difficulty getting out of bed in the morning? _____
Does the child take a long time to become alert in the morning? _____
Does the child appear tired? _____
Has the child appeared sleepy or falls asleep watching television? _____
Has the child appeared sleepy or fallen asleep while riding in the car? _____

What have you found to be the most effective form of discipline? _____
_____
Is the discipline at home handled mostly by: Mother _____ Father _____
Describe how the child reacts to discipline. Any stubbornness? _____
_____

How does child get along with other children in the family? _____

_____

How does child get along with children not in the family? A leader? Follower? Playing with children who are older? Younger? _____

_____

What is the age and sex of your child's favorite playmate? _____
How does your child get along with others at school? _____

How would you describe your child's personality? _____
What activities does your child enjoy (include sports, clubs, favorite types of play, etc.)
Most ? _____ Least? _____
Does your child have unusual body movements (describe)? _____
When did your child show a clear hand preference? _____ Right _____ Left _____
Are there any left-handed family members? Yes _____ No _____ Who? _____

Educational Information

Child's Present Grade: _____ Name of School: _____
Address: _____ Telephone: _____
Teacher(s): _____

Has child repeated any grades? (Describe) _____
Did your child have difficulty leaving home or parents when starting school? _____

Please list names, grades, and locations of any other schools attended from kindergarten to present: _____

_____

_____

Did your child attend day care? _____ Where and when? _____
Did your child attend nursery school? _____ Where and when? _____
Did your child receive any Early Intervention services? _____ Where, when and what?

_____

Have there been any extended periods when the child did not or could not attend school?
□ Yes □ No If so, when? _____
Explain: _____

_____

If he/she continued to receive educational services during the school absence, please explain.

_____

_____

_____

Have any grades been repeated? □ Yes □ No If so, when? _____

GENERAL SCHOOL INFORMATION

Guidance Counselor ☐ Yes ☐ No	Name	School Psychologist ☐ Yes ☐ No	Name
Adjustment Counselor ☐ Yes ☐ No	Name	Other contact ☐ Yes ☐ No	Name

DESCRIPTION OF CURRENT SCHOOL

School level (Elem, MS, HS)			
Type of school (Public, voc, private, special , etc...)			
Classroom setting(s)			
Class organization	Grade	Name of regular classroom/ Home room teacher	
No. of teacher's aides, if any		Approximate no. of students in classes ▶	

SPECIAL AND /OR AUXILLARY SERVICES

Child has had a school evaluation Yes ☐ No In which areas: ▶	Pysch Ed _____ S/L _____ OT _____ PT _____ Emotional _____ Other _____	Dates
Child has IEP ☐ Yes ☐ No	504 ☐ Yes ☐ No	Date

Services in IEP :		
☐ Speech	☐ Academic Services	☐ Adjustment Counseling
☐ Physical Therapy	☐ Occupational Therapy	☐ Other :

Does the child receive extra help for (ie Title 1 or other remedial instruction) any of the following? ☐ Reading ☐ Math ☐ Other subject/basic skills:_____

For each area above, please answer the following questions (use back of form if needed).		
Area of difficulty :	No. days/ week:	Length of each session:
Extra help given: ☐ within ☐ outside classroom	Where is help given?	
Name of therapist(s):	Therapist/student ratio: 1 therapist to _____ students	

List the subjects this child is taking and place a check in the correct column indicating how well he/she is doing in each subject. If you wish to specify grades, please do so.

ACADEMIC SUBJECT	EXC	GOOD	AVG	BEL AVG	FAIL	GRADE

OTHER RELEVANT CLASSROOM INFORMATON

Compare the child's grades this year to last year and check appropriate box.

□ Sharp Decline □ Slow but steady decline □ No change □ Slow but steady improvement □ Marked improvement

Decribe the child's present overall school performance/progress.

□ Declining □ Average □ Improving

What is the child's attitude towards school? Is he/she basically happy, involved, frustrated, unhappy, indifferent, etc. with school? Please elaborate.

_____

_____

_____

List some of the activities and interests the child enjoys outside of school (sports, clubs, etc.)

_____

_____

Describe in detail his/her career or job goals and desires to attend vocational, technical school, college, or a post-secondary program.

_____

_____

What are your child's academic strengths? _____

_____

What are your child's academic difficulties? _____

_____

Does he/she enjoy and feel successful in school? _____ Please explain: _____

_____

What are your child's best qualities? _____

_____

What are your child's most difficult qualities to deal with? _____

_____

In what ways do you think this evaluation could be most helpful with your child?

_____

_____

_____

_____

Please feel free to add additional comments below or on the reverse side.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Reminder : Please attach copies of all IEP's and previous test reports.

_____

Parent or Guardian Signature Date

_____

Parent or Guardian Signature Date

LIFEDIMENSIONS
NEUROPSYCHOLOGICAL SERVICES, INC.

----PROTOCOL TO ACCESS IN-PERSON NEUROPSYCHOLOGICAL SERVICES --

250 Pond Street Braintree, MA 02184
Office Telephone: 781-348-2258 Fax: 781-348-2132

Dear Patient:

For us to provide you with in-person services, we require you to read all of this protocol so you can confirm your understanding of and agreement to the information below with your neuropsychologist. We look forward to your appointment. Please note you cannot enter the hospital without a mask.

ENTERING THE HOSPITAL TO ACCESS IN-PERSON NEUROPSYCHOLOGICAL SERVICES

1. You agree not to present for in-person services if you have a fever, shortness of breath, coughing, or any other symptoms of illness or if you have been exposed to a person who is ill or with confirmed COVID-19 within the past two weeks.
2. Masks are required to enter the hospital. Patients must attend appointments wearing freshly cleaned clothes.
3. If you are bringing a child or other dependent to the appointment, you agree to the following. Only one additional person may accompany the patient to the appointment.
   - For a child's appointment, only 1 adult can enter the hospital for the appointment.
   - For an adult's appointment, only 1 other adult can enter the hospital for the appointment.
4. You will be asked to wait in your vehicle until you receive a phone call from our office staff to ask you to enter the hospital. If you do not have a cell phone, you will be asked to enter the hospital no more than 5 minutes before your appointment and to wait in the lobby. We suggest you bring a charged cell phone.
5. To enter the hospital, you must wear your mask and use the hand sanitizer located at the hospital entrance. Then, you will go to the receptionist's desk, where you will have your temperature taken. Do not leave the reception area until you are escorted by the neuropsychologist to the office.
6. Social distancing must occur, meaning you must maintain a 6-foot distance from others in all areas. Please refrain from any physical contact or shaking hands with staff members.

ACCESSING IN-PERSON NEUROPSYCHOLOGICAL SERVICES

7. For your health and that of our staff, hand sanitizer will be available and used throughout the appointment as well as hand washing. Patients must wear masks and the neuropsychologist or psychometrist will wear masks and/or face shields unless there is a clinically significant restriction that must be successfully addressed; otherwise, the appointment will not continue.
8. Please bring any snack food or beverages you require for the duration of the appointment. However, if a lunch break is scheduled for a longer appointment—please note the cafeteria is closed and you must plan to eat outside the hospital.
9. Specific accommodations for the *adult* accompanying the patient, the child, adolescent, or adult requiring assistance *while* the evaluation occurs must be made in advance with the neuropsychologist. We recommend the adult accompanying a child remain close by in a car or one, designated area in the hospital so the neuropsychologist can contact the adult as needed throughout the entirety of the appointment.

We are committed to following and adhering to prevailing healthcare standards.

By signing below, you acknowledge you understand and agree to follow the protocol as outlined to utilize in-person services for your appointment. We thank you for your commitment to the health and wellbeing of us and our community.

_____	_____
Patient/Client	Date
_____	_____
Neuropsychologist	Date

LifeDimensions Neuropsychological Services, Inc.

CONSENT AND AUTHORIZATION FOR EVALUATION TREATMENT

Client Name_____
Guardian Name_____

_____will be providing you with neuropsychological assessment/ consultation services as requested by you and your referral source. Prior to beginning the treatment process, you will need to read and consent to the following, acknowledging your agreement.

CONSENT TO TREATMENT: You must consent to treatment before the neuropsychological evaluation can begin. You have the right to ask any questions about the evaluation and assessment process. You may terminate your assessment at any time. Services completed, however, can be billed. Confidential information contained in your record / file will remain confidential in accordance with state and federal regulations and laws.

CONSENT TO OBTAIN AND/ OR RELEASE INFORMATION: As your assessment is planned, information may be needed from the clinicians with, whom you previously were treated and/ or school based professionals. As the assessment recommendations are written, consultation with existing or new clinicians or other professionals within your school may occur. Release of the report will also occur. You will need to provide permission for me to request information for and release information about the assessment and treatment recommendations.

ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF FINANCIAL RESPONSIBILITY: By signing, you authorize payment directly to LifeDimensions Neuropsychological Services. You agree to accept financial responsibility for charges not covered by third party coverage and to make payment upon receipt of the billing statement for the amount owed to LifeDimensions Neuropsychological Services, Inc.

AGREEMENT: By signing below, I am agreeing to consent to treatment to allow _____to obtain and release information and/ or records, and to the payment conditions. I also acknowledge that I received information about the potential benefits and harm that might result from neuropsychological assessment. I understand that I can change my mind about this agreement at any time.

_____

Signature of Client Date

_____

Signature of Guardian Date

_____

Signature of Witness Date

LIFEDIMENSIONS
NEUROPSYCHOLOGICAL SERVICES, INC.

Authorization Form (updated 7/31/2015)

Patient Name: _____ Date: _____

This form, when completed and signed by you, authorizes LifeDimensions Neuropsychological Services, Inc. (hereafter referred to as *LifeDimensions*) to release protected information from you, your child, or ward's clinical record to the people and institutions you designate. You agree that the individual(s) involved may also provide information to **LifeDimensions Neuropsychological Services, Inc.**, ***unless you specify otherwise*** *(under restrictions, below).*

The transmission of information by electronic means (e-mail, fax) cannot be guaranteed to be secure or private. Please check next to the appropriate spot(s) if you authorize **LifeDimensions Neuropsychological Services, Inc.** to transmit written information:

-by **fax** ..... ☐Yes ☐No
-by **e-mail**..... ☐Yes ☐No

The following types of health information may be given special legal protection, and may be released only with a separate authorization for each one that applies. If applicable, **initial** below:

_____HIV status/test results
_____Alcohol and Drug Use/Abuse
_____Domestic Violence Victims' Counseling

This authorization shall remain in effect until three years from today, or *until otherwise specified by me*, as follows:

_____.

By signing this form, I am indicating that I understand the following:

-I have the right to revoke this authorization, in writing, at any time by sending such written notification to **LifeDimensions Neuropsychological Services, Inc.**'s mailing address. However, my revocation will not be effective to the extent that **LifeDimensions Neuropsychological Services, Inc.** has already taken action based upon this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

LifeDimensions Neuropsychological Services, Inc. *generally* may not refuse psychological services upon my signing this authorization unless the psychological services are provided to me for the purpose of creating health information for a third party, such as a forensic exam; or if another complicating factor arises that makes it impractical, inappropriate or unethical to complete the examination as planned.

Be aware that there is a risk that information used or disclosed related to this authorization may be subject to re-disclosure by whoever receives this information, and therefore no longer protected by the HIPAA Privacy Rule.

LifeDimensions Neuropsychological Services, Inc. will request that I have the opportunity to limit the uses or disclosures that I will make as follows: that I will not provide copies of any test protocols and/or raw data to anyone, except: (1) when you authorize me to provide copies to another neuropsychologist: or (2) when required to do so by court order to allow.

Patient Name: _____ Date: _____

LifeDimensions Neuropsychological Services, Inc. reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

LifeDimensions Neuropsychological Services, Inc. is required by law to maintain the privacy of, and provide individuals with, this notice of my legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with me in person or by phone at 781-348-2258.

_____ _____

Signature of Patient or Responsible Person **Date**

_____ _____

Printed Name **Relationship to patient**

_____ _____

Printed **name of Patient (if not you)** **Patient's Date of Birth**

****

Information should be released to and from the following (*please provide the name, address, telephone, and fax of person(s) or institutions to/from whom the information is to be released.* ***Please put only one name per box below***):

PLEASE COMPLETE THOROUGHLY AND ACCURATELY, WITH FULL NAME AND ADDRESS, OR WE WILL NOT BE ABLE TO FORWARD THE REPORT.

Name of person/institution to share information with: _____
Relationship to patient (such as "neurologist" or "daughter"): _____
Address: _____
_____
Telephone: _____ Fax: _____

for the following reason(s):
□ Medical Care □ Insurance □ School □ Legal/forensic □ Personal □ Other _____

I authorize the following types of communication between this person/institution and **LifeDimensions Neuropsychological Services, Inc.**:
Sharing **written reports** and other medical records? ☐Yes ☐No
Verbal communication (like phone calls and in-person discussions? ☐Yes ☐No

Patient Name: _____ Date: _____

This space is available to add additional names:

Name of person/institution to share information with: ____________________
Relationship to patient (such as "neurologist" or "daughter"): ____________________
Address: ____________________
____
Telephone: ____________________ Fax: ____________________

for the following reason(s):
□ Medical Care □ Insurance □ School □ Legal/forensic □ Personal □ Other ____________

I authorize the following types of communication between this person/institution and **LifeDimensions Neuropsychological Services, Inc.**:
Sharing **written reports** and medical records? ❑Yes ❑No
Verbal communication (like phone calls and in-person discussions? ❑Yes ❑No

Name of person/institution to share information with: ____________________
Relationship to patient (such as "neurologist" or "daughter"): ____________________
Address: ____________________
____
Telephone: ____________________ Fax: ____________________

for the following reason(s):
□ Medical Care □ Insurance □ School □ Legal/forensic □ Personal □ Other ____________

I authorize the following types of communication between this person/institution and **LifeDimensions Neuropsychological Services, Inc.**:
Sharing **written reports** and medical records? ❑Yes ❑No
Verbal communication (like phone calls and in-person discussions? ❑Yes ❑No

Name of person/institution to share information with: ____________________
Relationship to patient (such as "neurologist" or "daughter"): ____________________
Address: ____________________
____
Telephone: ____________________ Fax: ____________________

for the following reason(s):
□ Medical Care □ Insurance □ School □ Legal/forensic □ Personal □ Other ____________

I authorize the following types of communication between this person/institution and **LifeDimensions Neuropsychological Services, Inc.**:
Sharing **written reports** and medical records? ❑Yes ❑No
Verbal communication (like phone calls and in-person discussions? ❑Yes ❑No

For Provider Use ONLY:

Provider Name: **Diagnosis Code:**

Referring Provider: **Authorization #:**

COMPLETE AND ACCURATE INFORMATION IS REQUIRED

PATIENT

Patient Name_____ SS#_____

Address_____

City_____State_____Zip_____

Date of Birth_____ Male _____ Female_____ Marital Status_____

Home Phone_____ Work Phone _____

RESPONSIBLE PARTY Name & address of person responsible for any balance not covered by insurance:

☐ Same as Patient ☐ Other

Name_____

Address_____ City_____State_____Zip_____

Home Phone_____ Work Phone _____

INSURANCE Include copy of front & back of insurance card

Primary Insurance_____

Insurance Address_____Phone_____

City_____State_____Zip_____

Subscriber #: _____ Group#: _____

Secondary Insurance_____

Insurance Address_____Phone_____

City_____State_____Zip_____

Subscriber #: _____ Group#: _____

SUBSCRIBER

☐ Same as Patient ☐ Same as Responsible Party ☐ Other

Subscriber Name_____ Date of Birth _____ SS#_____

Patient Relationship to subscriber: Self____ Spouse____ Child____ Other (specify)_____

Employer_____Phone_____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize the Provider of service to furnish information to insurance carriers concerning my condition and treatment. I hereby assign to the provider all payments for medical services rendered to my dependents or myself. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature_____ **Date** _____

LIFEDIMENSIONS
NEUROPSYCHOLOGICAL SERVICES, INC.
located at Braintree Rehabilitation Hospital
250 Pond Street Braintree, MA 02184
781-348-2258 www.lifedimensionsnp.com

From Boston
Follow **Route 93 South** (*also known as the Southeast Expressway*).
At the Route 93 and Route 3 split, **bear right toward Dedham** (***do not*** *bear left toward Braintree / Cape Cod*).
Take **Exit 6 toward Route 37 South** and follow **Route 37 directions below.**

From the West
Take the **Massachusetts turnpike to Route 128 / South Shore Exit**
(*at this point the road is also known as Route 95 / Route 93*).
Stay straight on **Route 93** (***do not*** *bear right to Route 95 South toward Providence*).
The exit numbers will change, continue to **Exit 6**.
Take Exit 6 to **Route 37 South** and follow **Route 37 directions below**.

From Fall River / New Bedford
Follow **Route 24 North** to end.
Bear right onto **Route 128 toward Braintree / Cape Cod**.
Take **Exit 6 to Route 37** and follow the **Route 37 South directions below**.

From Route 37 South
Follow **Route 37 South** for almost 1 mile until you reach a **five-way intersection** (*Braintree Five Corners*).
Bear left (***not*** *a sharp left*) at this intersection,
keeping TD Bank on your left and Bertucci's on your right.
Stay on Route 37 South until you see a large white church on your right.
Turn right onto Pond Street. Braintree Hospital is located approximately **½ mile down on your left**.

From Cape Cod / South Shore
Follow **Route 3 North**.
Take **Exit 17** and follow the rotary. Take your **third exit off the rotary** (*South Braintree*).
Close straight through the traffic light, up the hill and **turn left onto Washington Street**.
At the next intersection / traffic light **turn right onto Central Avenue**.
At the end of the road, **turn left onto Route 37 South**.
Follow Route 37 South until you see a large white church on your right.
Turn right onto Pond Street. Braintree Hospital is located approximately **½ mile down on your left**.