Neuropsychological Evaluation Report Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A neuropsychological evaluation report is the written product of neuropsychological testing: it integrates the referral question, history, behavioral observations, and standardized cognitive test scores into a domain-by-domain interpretation, a diagnosis, and functional recommendations. It goes to the referrer, and the patient will usually read it too.

Identifying information & referral question the question is the spine of the report
Do: state who the patient is, who referred them, and the specific question this evaluation exists to answer, in a sentence or two.
Pitfall: restating a vague "memory problems, please evaluate" referral; interpretation with no target reads as testing for its own sake.

Notification & consent purpose, fees, limits, audience
Do: record what the patient was told about the purpose, the fees, confidentiality limits, and who receives the report.
Pitfall: silence about who gets the report; access disputes start exactly where the record says nothing.

Sources & tests administered instruments, examiners, and the clock
Do: list every instrument by full name, who administered each (evaluator or psychometrist), and the cumulative hours.
Pitfall: omitting time; the US testing codes are time based and cumulate across the whole episode of care.

Relevant history the baseline that makes decline readable
Do: cover medical, neurological, psychiatric, developmental, educational, occupational, substance, and family history.
Pitfall: no premorbid anchor; without best-ever functioning (grades, degrees, job complexity), "below average" cannot be read as change.

Observations & performance validity are the data interpretable?
Do: describe presentation and engagement, then state explicitly whether performance validity indicators support interpretation.
Pitfall: no validity statement; in a discipline built on effort-dependent measures, unvalidated data support nothing.

Results by cognitive domain prose, not printouts
Do: organize by domain: premorbid estimate, attention and speed, language, visuospatial, memory, executive, motor, mood.
Pitfall: an instrument-by-instrument score dump; payers pay for evaluation, and tables without integration document administration only.

Summary & clinical impressions answer the question, state the etiology
Do: pull history, observations, and testing into one clinical picture that answers the referral question and states the most likely cause.
Pitfall: the hedge-everything summary; the referrer needed a position, with its confidence stated honestly.

Diagnostic impression a conclusion either way
Do: give the DSM-5-TR diagnosis with its ICD-10-CM code and rule-outs, or state that no diagnosis is supported and what justified testing.
Pitfall: skipping the line when results are normal; policy expects the suspected diagnosis even when none is found.

Functional recommendations & sign-off the section everyone reads first
Do: translate findings into work, school, driving, and independence terms; number each; name a re-evaluation trigger.
Pitfall: cognitive findings with no functional translation; the neurologist, the family, and the insurer all read this section first.

Before you sign

- [ ] Summary answers what the referrer asked
- [ ] Performance validity stated before interpretation
- [ ] Results organized by domain, not instrument
- [ ] Premorbid baseline anchors any claim of decline
- [ ] Examiners and cumulative hours recorded
- [ ] Recommendations are functional and traceable
- [ ] Credentials signed; supervisor where needed

Drafting with AI

Capture 30 seconds of bullets after scoring: referral question, instruments with key scores, validity note, premorbid estimate, impression, functional recommendations.

> *"Draft a neuropsychological evaluation report from these results, 68-year-old referred for memory complaints, TOPF high average, CVLT-3 delayed recall impaired with limited recognition benefit, validity indicators normal: …"*

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

5–20 pages	**4–10 hrs after testing**	**After a testing battery**	**Referrer · patient · rehab · insurers**
typical length	clinical team estimate	when it is written	who reads it

Full guide and sample report:
bastiongpt.com/template/neuropsychological-report

BastionGPT drafts the report from your scores and notes. Free 7-day trial.

Neuropsychological Evaluation Report Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Patient (initials): | DOB / age: | Dates of service: | Report date:

Evaluator / credentials / license #: | Psychometrist (if any): | Referral source:

Referral question
The specific question this evaluation should answer, in one or two sentences

Notification & consent
Purpose, fees, confidentiality limits, who receives the report; feedback session planned

Sources of information
Interview (date, length), records reviewed, collateral informants

Tests administered
Full instrument names; who administered each (evaluator / psychometrist); administration, scoring & interpretation time

Relevant history
Medical / neurological / psychiatric; developmental; educational / occupational (premorbid baseline); substance; family

Observations & performance validity
Presentation, engagement; explicit statement that performance validity indicators support (or do not support) interpretation

Results by cognitive domain
Premorbid estimate; attention / processing speed; language; visuospatial; learning & memory; executive; motor; mood screen. In prose, anchored to baseline

Summary & clinical impressions
One integrated picture; answer the referral question and state the most likely etiology

Diagnostic impression
DSM-5-TR / ICD-10-CM with rule-outs, or "no diagnosis supported" plus the suspected diagnosis that justified testing

Functional implications & recommendations
Numbered, tied to findings: work / school / driving / medications / independence; referrals; re-evaluation trigger

Evaluator signature / credentials: | Supervisor signature (if required): | Date signed: