Referral Form for Psychological Testing/Assessment

To be completed by the referring provider:

Date: _____ Completed by: _____

Patient's name: _____ DOB: _____

Parent/guardian: _____ Phone _____

Reason for Referral/ Referral Question:

What is/are the patient's working diagnosis currently?

Which diagnoses would you like confirmed or ruled out?
Please send records with your observations about these.

□ Intellectual developmental disorder
□ ADD/ADHD
□ Autism spectrum
□ Learning disorder
□ Mood disorder (Specify _____)
□ Anxiety Disorder (Specify _____)
□ Personality disorder (specify _____)
□ Other: _____

Specify: □ needs assessment to qualify for special programs
□ may need accommodations for school

Other specific questions you would like answered:

Has the patient received another mental health diagnosis in the past? If so, list:

Has the patient ever had a psychological evaluation? If so, when and where?

PLEASE SEND ANY RELEVANT CURRENT OR PAST RECORDS.
PLEASE NOTE WE ARE UNABLE TO ACCEPT MEDICARE OR MEDICAID FOR EVALUATIONS AT THIS TIME.

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