Evaluation/Psychological Testing Referral Form
(External Providers)

ALL FIELDS IN TOP SECTION AND CLIENT BILLING SECTION MUST BE COMPLETED

Client Name: _____ **Date of Request:** _____

DOB _____ **Age:** _____ **Client Phone Number:** _____

If Minor, Name of Parent/ Guardian: _____ **Phone Number:** _____

Referred By: _____ **Release Signed:** ☐ Yes ☐ No

If a psychological evaluation or test is requested, what is the question to be answered with the evaluation?

_____

Court Ordered? ☐ Yes ☐ No **Request copy of court order if necessary
For Legal Offense? ☐ Yes ☐ No Court/Judge/Attorney: _____

Able to Read? ☐ Yes ☐ No **Intellectual Concerns:** ☐ Yes ☐ No

List Physical Limitations: _____

Reason for Assessment:
☐ Intelligence/IQ ☐ Learning Disorder ☐ Autism Screening ☐ ADHD
☐ Personality ☐ Memory Problems ☐ Other: _____

Client Billing Information

Responsible Party: _____ **Employer:** _____

Insurance: _____ **Policy #:** _____

SSN: _____ **DOB:** _____ **Phone Number:** _____

Address: _____
City **St** **Zip**

Office Use Only

Amount Due: $_____ ☐ Insurance/Billing Approval Date: _____
☐ Payment Received Date: _____

Director's Approval to Schedule: _____ **Date:** _____

Appt. Date: _____ **Appt. Time** _____ ☐ Am ☐ PM

Provider: _____