PSYCHOLOGICAL TESTING REFERRAL

Please fax to 833-779-9675 or secure email this form to
admin@psychologyworksplic.com

Patient Name: _____ **Date of Referral:** _____

DOB: _____ **Age:** _____ **Grade/School:** _____ **Parent(s):** _____

Referring Professional(s): _____ **Patient's Phone Number:** _____ **Email:**_____

Current Therapist: _____ **Current Medication Provider:** _____

Insurance: _____ **Pre-Auth Needed?** ☐ **No** ☐ **Yes**

CLINICAL REASONS FOR REQUESTING EVALUATION (please check all that apply):
☐ Diagnosis unclear ☐ Not progressing in mental health treatment ☐ Change in daily functioning ☐ Autism
Questions/concerns about: ☐ social/interpersonal ☐ emotional ☐ cognitive functioning
☐ Recommendation from prior assessment or current mental health services ☐ ADHD ☐ Court Requested

Has the patient had a previous psychological evaluation? ☐ Yes ☐ No ☐ Don't Know

Briefly describe what event(s) in the case or what aspects of the individual's behavior lead to a referral for an evaluation at this time:

_____

_____

_____

What question(s) would you like to have answered by the testing?

_____

_____

_____

Current or Provisional DSM-V Diagnosis:

_____

Relevant Medical Issues: _____

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833-779-9675

For PsychologyWorks' office use only:	Was patient scheduled? If not, why?	Was this form uploaded to their chart?