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PSYCHOLOGICAL EVALUATION REFERRAL FORM

- Referral form is *required* before scheduling
- Please mail/fax in the copy of completed form, along with insurance card(s)

TO BE COMPLETED BY CASE MANAGER, THERAPIST, OR OTHER PROFESSIONAL

Guidelines for Considering Psychological Evaluation

Contemplate...

- "Given the information I know about this person, what do I need to know further?" and "Will a psychological evaluation provide me this answer?"
- "Will the client be honest and forthcoming with information?" A psychological evaluation will likely not provide information from a defensive or difficult client. Rather, you may have more success with building an ongoing relationship, such as in therapy.
- Evaluations can be time consuming, evasive, and sometimes traumatizing. "Will the evaluation cause a detrimental impact to my client?"
- "Has this client had an evaluation before?" Please avoid testing if they have received an evaluation within the last two years.

An evaluation may be helpful when...

- To determine a DSM diagnosis.
- To differentiate between DSM diagnoses.
- There is little to no existing clinical information.
- There is an unexplained decline in functioning and the reason is unclear (i.e., not related to drugs, alcohol, or a significant life stressor).
- There are indications specific interventions may be beneficial.

It is best not to refer when...

- The client is actively abusing drugs or alcohol.
- The client is in process for a placement where an evaluation will be conducted.
- The client has difficulties only in school academics and may be better evaluated by a school psychologist or other school staff.
- The question to the client's symptoms would be more properly assessed by another type of service or evaluation, such as substance use, domestic violence, or psychiatric.

Client Information Preferred name/pronouns ______________________

Sex/Gender ______________ Phone ______________

Legal Name ______________________ DOB ______________

Address ______________________________________

Parent/Guardian (if applicable)

Name ______________________________________

Daytime Phone ______________ Cell Phone ______________

Can we leave a message: ______________

Contact for Scheduling

Name ______________________________________

Daytime Phone ______________ Cell Phone ______________

Can we leave a message? ______________

Can we text for scheduling purposes? ________ Phone # to text: ______________

Referring Provider

Name ______________________ Agency ______________

Agency address: ______________________________________

Relationship to client: ______________ Work # ______________

Fax ______________ Email ______________________

Send completed report by ______________________

Insurance Information - All insurances must be listed

Name of Primary Insurance ______________________________

ID # ______________________ Group ID ______________

Name of policy holder (if different than client) ______________

Policy Holder DOB ____________________________________

Name of Secondary Insurance ____

ID # ________________________ Group ID ____________________________________

Name of policy holder (if different than client) ____________________________________

Policy Holder DOB ____________________________________

Medical Necessity

For insurances to reimburse for psychological testing, the testings must be Medically Necessary. Medically Necessary means: a service of which in the opinion of the service provider is reasonably needed to prevent the worsening of the condition, to establish a diagnosis and/or assist the covered individual to achieve maximal functional capacity. Please clearly define the medically necessary reasons for the individual to receive testing. Also, list current concerns and goals for the assessment. Please attach an additional sheet if needed.

Reason for referral, please check all that apply

__ Assist with diagnosis
__ Evaluate current functioning/strengths/limits
__ Assist with a specific differential
__ Compare to prior eval, assess interval change
__ Establish cognitive baseline
__ Psychological factors (mood, personality, etc.)
__ Unexplained functioning change
__ Not progressing in current treatment
__ Concern about appropriate mental health treatment
__ Other (please describe)

Provide recommendations, please check all that apply

__ Treatment recommendations
__ Work considerations
__ Placement considerations
__ Other (please describe)
__ Daily functioning considerations (e.g., driving)
__ Academic considerations

Current services, please check all that apply

__ Individual therapy/counseling
__ Psychiatric care
__ ARMHS
__ Foster placement
__ Wrap around services
__ Family decision making
__ Family/relationship counseling
__ Residential placement
__ Inpatient mental health
__ Special education
__ Intensive outpatient programming
__ Specialized therapies (Please describe)
__ Respite care
__ CTSS
__ Medical care
__ Court system

__ Other (Please describe)

History, please check all that apply (Copies of any prior assessments, medications, and discharge summaries, etc. are helpful)

__ Mental health
__ Non Suicidal Self-Injury
__ Abuse (Emotional, sexual, etc.)
__ Suicide attempts
__ Mental health inpatient
__ Physical therapy
__ Medical care
__ Developmental disability
__ Neglect
__ Domestic violence
__ Partial hospitalization
__ Speech therapy
__ Medication
__ Early Intervention
__ Substance abuse
__ Legal problems/arrest
__ Residential
__ Occupational therapy
__ Other (please describe)

Who are the client's current and previous service providers?

What are the client's current and previous diagnoses?

Please list any current and previous psychotropic medications, including dosages and the patient's response.

What are the client's complaints?

__ Anxiety
__ Concentration
__ Inattention
__ Non Suicidal Self-Injury
__ Atypical behavior
__ Changes in memory
__ Flashbacks
__ Other (please describe)

__ Depression
__ Fatigue
__ Hyperactivity
__ Suicidal ideation
__ Dissociation
__ Irritability/agitation
__ Loss of pleasure

__ Social withdrawal/isolation
__ Psychosis/Hallucinations
__ Eating disorder symptoms
__ Unprovoked aggression
__ Mood instability
__ Panic attacks

Provider cognitive concerns

__ Memory __ Attention __ Processing speed __ Executive functioning
__ Language __ Visuospatial __ Judgment __ Symptom validity
__ Other (please describe)

Provider psychological concerns

__ Depression __ Anxiety __ Personality __ Substance misuse
__ Sleep problems __ Other (please describe)

Provider motor concerns

__ Gait changes __ Recent falls __ Tremors __ Other (please describe)

Medical history of

__ Delirium __ Stroke __ Seizures __ Anoxic/hypoxic injury
__ Head injury __ Toxic exposure __ Visual, hearing, or physical impairment
__ Details/Other (please describe)

Family history of

__ Depression __ Anxiety __ ADHD __ Bipolar
__ PTSD __ Substance abuse __ Personality disorders __ Legal problems
__ Autism spectrum __ Dementia __ Psychosis/Hallucinations
__ Suicide attempts or completion __ Aggression/behavioral outbursts
__ Details/Other (please describe)

Demographic and Special Considerations

Race ________________________________ Language(s) ________________________________

Interpreter needed? __________________ LGBTQIA+ ________________________________

Living situation (blended family, foster, multiple moves, etc)?

Do you believe the client is actively using substances?

__ Yes __ No __ Recent rehabilitation __ Intermittent usage

__ Alcohol __ Tobacco __ Marijuana __ Methamphetamine

__ Other

Indicate type, frequency, duration

Developmental and Education History

Concerns about developmental delay? __ No __ Yes (Details)

Current or history of

__ Suspension __ Special education services __ Grade repeat

__ Expulsion __ Social problems with peers __ Teacher concerns

__ IEP/504 (Helpful if copy available)

__ Details/Other (please describe)

Any other information not asked that is important to know?

Please attach required documentation. Referral may not be able to be processed if not included.

- All previous psychological or other professional evaluations, including psychosocial and mental health assessments
- Educational records, grade report, IEP, 504 plan, school testing, incident reports
- Court referral for evaluation/court report
- Mental health discharge summary, current treatment plan, progress report and/or treatment summary, current medication list

Signature ______________________________ Date ____________________

Print name ______________________ Relationship to client ____________________