Counseling and Wellness Services

Referral for Psychological Evaluation

Complete form and fax. We will contact the client and advise you of the outcome.

Date of referral: ____________________

Referral source:	Phone:
Agency:	Fax:
Name of client:	
If child, primary caregiver(s):	Relation:
Legal guardian (if applicable):	Phone:

Reason for referral/ Referral question:

Evaluate for Neurodevelopmental disorders: (check all that apply)	
□ Developmental disability	□ Autism
□ Learning disability	□ ADHD
Evaluate for psychiatric diagnosis or treatment recommendations: (specify concerns)	
Evaluate for medical reason (specify) □ Bariatric weight loss surgery □ Spinal cord stimulator surgery □ Interferon treatment	
Evaluate for pre-employment (specify field):	

Payment information (please check all that apply):

□ BCBS □ Medcost □ Tricare □ UHC/Optum/UMR □ Cigna □ Medicare	□ Other (specify) ____________________ □ Self pay □ Third party: □ Attorney □ Workers Compensation (list carrier & billing information) ____________________ ______________________________________ ______________________________________

PLEASE SEND ANY RELEVANT RECORDS. THANK YOU FOR YOUR REFERRAL.

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