San Mateo County Health System

Behavioral Health and Recovery Services

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

REFERRAL for PSYCHOLOGICAL EVALUATION

SECTION I: COMPLETED BY CLINICIAN

Date _____

Name of Person Referred for Evaluation _____

Phone # _____ DOB _____ BHRS Record # _____

Referring Clinician _____ Phone # _____

REQUIRED DOCUMENTATION

- ☐ Client's *Social History* updated within the past 30 days.
- ☐ Additional records, such as previous *psychological evaluations, treatment, court or educational records*.
- ☐ If the client is in mental health treatment, a *treatment summary* updated within the past 90 days.

CLINCIAL REASONS FOR REQUESTING EVALUATION (Please check all that apply.)

☐ Diagnosis unclear	☐ Parenting ability uncertain	☐ Not progressing in mental health treatment
☐ Change in daily functioning	☐ Question about social/interpersonal, emotional or cognitive functioning at home, school or community	☐ Recommend from prior assessment or current mental health services

☐ Other _____

Do you believe the individual is actively using alcohol or drugs? ☐ Yes ☐ No ☐ Don't Know

Has the client ever participated in mental health or substance abuse services? ☐ Yes ☐ No

Has the client had a previous psychological evaluation? ☐ Yes ☐ No

List the client's current medications. _____

_____

_____

CLIENT PRESENTS WITH SPECIAL NEEDS THAT MUST BE ACCOMMODATED DURING THE EVALUATION

- ☐ Primary language other than English (specify)
- ☐ Hearing-impaired
- ☐ Physically-disabled
- ☐ Vision impaired
- ☐ Out-of-Office testing needed (e.g., client in hospital, DOC)
- ☐ Other

Please describe what event/s in the case or in the individual's behaviors lead to referral for a psychological evaluation at this time. _____

_____

_____

_____

_____

Signature of Clinician _____ Date _____

Signature of Supervisor _____ Date _____

Name of Supervisor _____ Phone _____

SECTION II: COMPLETED BY CONSULTING PSYCHOLOGIST

The BHRS Consulting Psychologist may discuss with the clinician to complete the following information. An in-person or telephone consultation will be requested if needed.

This request for psychological evaluation is (check one):

☐ ***APPROVED***. In the space below, list and number referral questions to be addressed by BHRS Approved Psychological Testing Provider. Include any recommendations for specific types of testing needed (e.g. adaptive functioning, achievement). Provider will copy verbatim these questions in the Referral Question section of Provider's Psychological Evaluation report.

Check type of evaluation required:

☐ **Intelligence**	☐ **Neuropsychological**	☐ **Personality**
☐ **Memory**	☐ **Developmental**	☐ **Academic/Learning**

☐ ***REJECTED/DEFERRED***. Use space below to explain reasons for doing so. If deferred, specify what additional information is needed before rendering a decision.

_____

_____

_____

_____

_____

_____

_____

Identify additional documentation from previous psychological evaluation, if provided._____

_____

Homebound or out-of-office testing is needed: ☐ Yes ☐ No

Person/s being evaluated _____

_____

Signature of Consulting Psychologist _____ Date _____

Printed Name of Consulting Psychologist _____ Phone _____