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.

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

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