

**Psychological Testing Referral Form**

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Title/Position of Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aspire Office Location: Choose an item. Click or tap here to enter text. Phone # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Insurance Information**

Primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Providers**

Psychiatrist/NP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurologist/Other Providers (please state profession): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnoses and Medications**

Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Non-Psychiatric Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information**

Please describe patient’s current symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is patient currently in outpatient treatment?  Yes  No Date OP treatment began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, is patient currently in other mental health treatment?  Yes  No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the specific question(s) to be addressed by psychological testing**:

Psychiatric diagnosis clarification

Help develop appropriate treatment plan or help understand lack of response to treatment

1. **Ascertain impact of following symptoms on the client's functioning and response to therapy (check all that apply):**

Inattention ..Low/Dysregulated mood  Anxiety or trauma  Disruptive/Aggressive Behavior

Disordered thought process

1. **Ascertain role of:**

Memory  Processing speed  Language on client's functioning/response to therapy

Impact of client's cognitive capacity on their general functioning/response to therapy

Impact of client's functional capability on their ability to cope with life demands across domains/response to therapy dangerousness assessment

Determine the clinical/functional significance of brain abnormality/injury

Screen for autism spectrum disorder (ASD) or other developmental disabilities\*

Screen for academic problems\*

\**Insurance does not typically cover full learning disabilities, language or ASD evaluations*

1. **If there are academic problems, please check those that apply:**

Reading

Writing

Receptive language

Expressive language

Mathematics

Inattention

Other: (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Please check the previous actions taken to address clinical issues above:**

Clinical interview

Structured diagnostic interview (e.g., ADIS, SKID)

Consultation with other mental health professions

Consultation with teacher

Individual therapy: type of therapy/protocol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family therapy: type of therapy/protocol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group therapy: type of therapy/protocol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychopharmacological treatment (see above for current medications)

1. **Please check below how the results of testing will facilitate meeting treatment goals or providing information beyond that currently available:**

Allow for most appropriate and comprehensive treatment plan

Help chose best fitting therapeutic intervention

Facilitate referral to more intensive intervention given severity of symptoms (e.g., residential)

Give information regarding importance of medication evaluation

Give information regarding importance of further evaluation

1. **Previous psychological or neuropsychological testing:**  Yes  No  Not known

If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By whom/site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has patient had a special education/CORE evaluation?  Yes  No  Not known

If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **504 Plan?**  Yes  No **IEP?**  Yes  No

1. Does the patient have known pertinent medical issues (include pregnancy/birth complications, brain injury, head trauma, lead poisoning, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. History of substance use/abuse:  Yes  No

If yes, what substance(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Approximate date of last use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approximate age at 1st use: \_\_\_\_\_\_\_\_\_\_\_\_\_

Substance abuse treatment?:  Yes  No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Psychological Testing Requested (check all that apply):** Cognitive testing (intellectual, verbal/non-verbal)

Educational testing (learning disabilities) \* not usually covered by insurance, can screen

Psychiatric diagnosis/personality (anxiety, mood disorder, psychoses, personality issues)

1. Neuropsychological testing:

ADHD/ADD (executive functioning)

Developmental (Autism spectrum disorder, MR, developmental delay/functional level)

Neurologic (aneurysm, tumor, TBI, seizures, concussion)

Dementia or other specific memory disorder, competency, or decision-making capacity

**Instructions:**

* Complete this Psychological Testing Referral form.
* **Scan or fax** form to **Patty Reynolds** [preynold@aspirehealthalliance.org](mailto:preynold@aspirehealthalliance.org) or **fax:** (781) 843-2418.
* Plymouth office personnel will determine if insurance covers testing and approval process.
* After a testing psychologist or psychology intern requests a psych testing referral, the patient will be assigned to this person. The psychologist/psychology intern will contact patient to schedule a psych testing intake appointment followed by testing appointments.
* Psychologist/Psychology intern requests and secures insurance authorization for testing before beginning testing.
* Psychologist/Psychology intern assigned to testing case decide on most appropriate battery of tests given referral concerns and other information listed on the form. Psychological interns will consult with their supervisor regarding test battery selection.

Thank-you!