

**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 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!