aspire health alliance
State Designated
Community Behavioral Health Center

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
2. **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*
3. **If there are academic problems, please check those that apply:**
   ☐ Reading ☐ Writing ☐ Receptive language ☐ Expressive language
   ☐ Mathematics ☐ Inattention
   Other: (please describe) _____
4. **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)
5. **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
6. **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
7. **Does the patient have known pertinent medical issues (include pregnancy/birth complications, brain injury, head trauma, lead poisoning, etc):** _____
8. **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: _____

9. 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)

10. 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 **Ana Carvalho Da Silva** acarvalh@aspirehealthalliance.org, (617) 774-6090 ext. 4316 or **fax:** (617) 770-3749.
- 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!