



REFERRAL FORM is needed PRIOR to scheduling. PLEASE PRINT LEGIBLY!

Mail/fax this referral form, please include if available:

- Copy of Insurance card(s)
• Client's PCP with the GEC listed as approved provider for assessment services
• Client's completed CCA
• Consent and Release can be signed in office if legal guardian is present at appointment.

Client Information: Male ___ Female ___ Client phone ___
Name ___ Age ___ DOB ___
Street ___ City ___ State ___ Zip ___
Contact Person for Scheduling:
Name: ___
Daytime Phone ___ Home Phone ___ Cell Phone ___
Can messages be left on answering machine? Yes ___ No ___
Can we text for scheduling purposes Yes ___ No ___ Phone # to text to: ___
Email Address ___
Legal Guardian ___ Phone ___
(If different from contact person for scheduling) home/cell e-mail
Address ___
Street ___ City ___ St ___ Zip ___

Referral Agent:
Name ___ Agency ___ Relationship to client ___
Street ___ City ___ St ___ Zip ___
Work # ___ Cell # ___ Fax # ___ E-mail ___
Send completed report by: ___ Fax ___ Mail

Insurance Information: PLEASE SEND COPY OF CARD(S)
Check all that apply:
Medicaid ___ Medicaid # ___ County ___
BC/BS ___ BC# ___ Name of Cardholder ___
Other insurance: ___ Insurance Name ___
Card # ___ Policy Holder ___ DOB ___
BOTH MEDICAID AND OTHER INSURANCE MUST BE LISTED. We do not accept Medicare. Please call office to check on other insurance.

Is this assessment court ordered? _____

Client's Current Diagnosis _____

Current Medication(s) _____

Prescribing Doctor _____

In order insurances to reimburse providers for Psychological Testing, the testing must be Medically Necessary. Medical Necessity is defined as; a service which in the opinion of the primary service provider is reasonably needed to prevent the worsening of a condition, to establish a diagnosis and/or to assist the covered individual to achieve maximum functional capacity. **PLEASE CLEARLY DEFINE THE MEDICALLY NECESSARY REASONS FOR THIS INDIVIDUAL TO RECEIVE TESTING.** Additionally, list current concerns and goals for this assessment. Please be as thorough as possible - attach a separate sheet if necessary.

Information below must be provided to determine eligibility for testing prior to scheduling:

Please check all that apply:

_____ Developmental/Cognitive and psychological assessment to assist with diagnostic clarification, assess current level of functioning and make recommendations for services and/or treatment if appropriate.

_____ Determination of eligibility for placement based on testing outcome.

_____ Required testing for IDD services

_____ Educational Testing (Please note: Insurances do not pay for academic testing)

CURRENT SERVICES : Please check and list specific providers below:

Therapy/counseling Psychiatric care Medical care Respite care

DSS Case Responsible Provider(s) Foster placement Residential Placement

Inpatient mental health Court System Special Education Specialized Therapies

PROVIDERS:

HISTORY: Please check all that apply: (*Copies of prior assessments are helpful if available)

Mental Health Services Medical Services Developmental Disability Medication

Early Intervention Special Education Domestic Violence Substance Abuse

Suicidal history Abuse/Neglect Criminal Record Prior Assessment*

Signature

Relationship to client

Date

Client's Name: