GRANDIS
Evaluation Center
Home Trust Bank Plaza 1011 Tunnel Rd Ste 220 Asheville, NC 28805
P: 828.299.7451 F: 828.299.7454 Email: info@GECtesting.com

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 <u>must</u> be provided to determine eligibility for testing prior to scheduling:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please check <u>all</u> 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: