CARDINAL
CLINICAL CONSULTING

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REFERAL FOR PSYCHOLOGICAL TESTING

Please complete the following information and attach any relevant supporting documentation. Our office will contact the patient to schedule their appointment.

Referring agency information

Your Name: _____

Agency: _____ **Position:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (___) ____-_____ Fax: (___) ____-____ Email:_____

Patient information

Name: _____
(First) (Middle) (Last)

Date of birth: ___/____/_____ **Age:** _____ **Sex:** ☐ Male ☐ Female

Parent/Caregiver Name (if applicable):_____

Patient/Parent is aware of and agrees to this referral: ☐ Yes ☐ No

Address: _____

City: _____ **State:** _____ **Zip:** _____

Preferred Contact Number: (___) ____-____ Additional Contact: (___) ____-_____

Email: _____

Type of Assessment: ☐ Self-Pay ☐ Bill through insurance:

Insurance Information

Plan Information:_____
Company Group/Policy # Member ID

Reason for referral

Diagnostic testing for (check all that apply):

□ ADHD

□ Autism Spectrum Disorder

□ Behavior/impulse control disorder (e.g., ODD)

□ Psychological condition (such as an anxiety- or mood-related condition)

□ Other:

□ Academic / learning disorder

*Note: LD diagnoses and associated tests are **not** covered by most insurance plans; patients should contact their local school district unless they are interested in self-pay services*

What, if any, previous diagnoses has this client received?

Other Information

Please include any notes about this patient's treatment history, including current medications (if applicable), or provide any other relevant information below:

Thank you for this referral. You may return this information either:

via mail:	via fax:	via email:
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