DIVERSE ASSESSMENTS & TREATMENT, LLC

TODD M. SIGLER, PSYD, LP, NCC

USE THIS FORM TO REQUEST A PSYCHOLOGICAL EVALUATION FOR AN ADULT (18+) APPLYING FOR COUNTY-BASED SERVICES

ARE YOU REQUESTING A PSYCHOLOGICAL EVALUATION FOR AN **ADULT** FOR 1) INTELLECTUAL DISABILITY, 2) AUTISM SPECTRUM DISORDER (ASD), 3) COMMUNICATION DISORDER, OR 4) NEUROCOGNITIVE DISORDER?

☐ **YES. COMPLETE THIS FORM.** ☐ **NO. I will not offer an appointment. *****

*** You may email me with details about your psychological evaluation needs. If you do, complete the PROSPECTIVE PATIENT INFORMATION & WHO SHOULD I CONTACT WITH QUESTIONS OR TO SCHEDULE? of this form along with sending an email to todd@DiverseAssessments.org. ***

GO TO CLINIC WEB PAGE BY CLICKING _____

PROSPECTIVE PATIENT INFORMATION

LEGAL FIRST NAME _____

LEGAL MIDDLE NAME _____

LEGAL LAST NAME _____

PREFERRED NAME _____

DATE OF BIRTH _____

PATIENT'S MOBILE PHONE (IF ANY) _____ ACCEPT TEXTS ___ **YES** ___ **NO**

PATIENT'S EMAIL (IF ANY) _____

ADDRESS_____ APT _____

CITY ___ _____ STATE _____ ZIP CODE: _____

GENDER Select _____

RACE _____

ETHNICITY _____

PRIMARY LANGUAGE _____ INTERPRETER NEEDED ☐ **YES** ☐ **NO**

SECONDARY LANGUAGE _____

WHO SHOULD I CONTACT WITH QUESTIONS/TO SCHEDULE?

FIRST NAME _____

LAST NAME _____

RELATIONSHIP TO PROSPECTIVE PATIENT _____

MOBILE PHONE _____ ACCEPT TEXTS ☐ **YES** ☐ **NO**

EMAIL _____

PRIMARY LANGUAGE _____ INTERPRETER NEEDED ☐ **YES** ☐ **NO**

PROSPECTIVE PATIENT HEALTH INFORMATION

IF RECORDS WITH PREVIOUS DIAGNOSES OR CURRENT MEDICATIONS ARE BEING SENT, NO NEED TO LIST THEM HERE.

DOES THE INDIVIDUAL HAVE ANY MEDICAL OR MENTAL HEALTH CONDITIONS? ☐ **NO** ☐ **YES**

Diagnoses _____

IS THE INDIVIDUAL CURRENTLY PRESCRIBED ANY MEDICATIONS? ☐ **NO** ☐ **YES**

Prescription(s) _____

INSURANCE INFORMATION

DO YOU WANT TO USE HEALTH INSURANCE TO COVER THE COST OF THE PSYCHOLOGICAL EVALUATION (AND INTERPRETER)?

☐ **YES. PLEASE COMPLETE INSURANCE INFORMATION BELOW**

☐ **NO. HOW WILL THE COST BE COVERED?** _____

If you provide a photo of **BOTH SIDES OF YOUR INSURANCE CARD(S)**, you do not need to complete this section. SENDING A PICTURE OF THE **FRONT AND BACK** IS PREFERRED. You can text (**612-688-1909**) or email it (todd@DiverseAssessments.org).

IF THE PROSPECTIVE PATIENT HAS *MEDICAL ASSISTANCE* WHAT IS THEIR **PMI#?** _____

PRIMARY INSURANCE NAME _____

PRIMARY INSURACNE ID# _____ PRIMARY GROUP # _____

SECONDARY INSURANCE NAME (IF ANY) _____

SECONDARY INSURANCE ID# (IF ANY)_____ GROUP # (IF ANY)_____

WHO REFERRED YOU?

FIRST NAME _____

LAST NAME _____

AGENCY/ORGANIZATION _____

RELATIONSHIP TO PROSPECTIVE PATIENT _____

MOBILE PHONE _____

WORK PHONE _____

FAX _____

EMAIL _____

WHO NEEDS TO ATTEND?

A knowledgeable person must attend the diagnostic interview to answer questions about the patient's daily living, communication, socialization, development, and current functioning, especially if county-based services are sought. For certain diagnoses such as Autism Spectrum Disorder, Intellectual Disability, Neurocognitive disorders someone must accompany the patient to provide information on past & present skills/functioning.

WHO WILL ATTEND THE APPOINTMENT AND TAKE PART IN THE INTERVIEW AND RESPOND TO QUESTIONS?

☐ **NOT SURE NOW, I WILL LET DR. SIGLER KNOW BEFORE THE APPOINTMENT.**

☐ **THE/THAT PERSON(S) IS/ARE** _____

INTERPRETER WANTED/NEEDED ?

PLEASE ANSWER THE FOLLOWING QUESTIONS ONLY IF AN INTERPRETER IS WANTED/NEEDED. LEAVE THIS SECTION BLANK IF YOU DO NOT REQUIRE AN INTERPRETER.

WHAT LANGUAGE SHOULD THE INTERPRETER SPEAK? _____ ___

PREFERENCE FOR A **MALE** OR **FEMALE** INTERPRETER? ☐ NO ☐ YES, GENDER Select _____

PLEASE ADD ANY ADDITIONAL INFORMATION ABOUT THE PROSPECTIVE PATIENT.