



# TODD M. SIGLER, PSYD, LP, NCC

## REASON FOR THE REFERRAL FOR PSYCHOLOGICAL SERVICES?

<input checked="" type="checkbox"/> SERVICE REQUESTED	EXAMPLES	COVERED BY INSURANCE?
<input type="checkbox"/> MEDICAL WAIVER FOR DISABILITY EXCEPTION	USCIS N-648 form for Naturalization	<b>NO</b>
<input type="checkbox"/> HARDSHIP/BURDEN FOR DEPORTATION PROCEEDING	USCIS Proceeding	<b>NO</b>
<input type="checkbox"/>	E.g., Academic, learning disability, etc.	<b>TBD</b>

## PATIENT CONTACT INFORMATION

FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_ LAST: \_\_\_\_\_  
 GENDER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PRIMARY PHONE #: \_\_\_\_\_  
 EMAIL: \_\_\_\_\_ RACE/ETHNICITY: \_\_\_\_\_ LANGUAGE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ APT# \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PERMANENT RESIDENT #: **A**-\_\_\_\_\_ BIRTH COUNTRY: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

## CONTACT INFORMATION FOR SCHEDULING APPOINTMENT & FOLLOW UP

WHO SHOULD I CONTACT TO SCHEDULE?: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
 EMAIL → \_\_\_\_\_ PHONE: \_\_\_\_\_ CELL  WORK  HOME

## REFERRAL AGENT INFORMATION

REFERRING AGENT (NAME/AGENCY): \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 FAX: \_\_\_\_\_ PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

## BACKGROUND AND MEDICAL INFORMATION

CURRENT DIAGNOSES: \_\_\_\_\_  
 CURRENT MEDICATIONS: \_\_\_\_\_  
 PRIMARY CARE PROVIDER: \_\_\_\_\_

## PATIENT FOR WAIVER EVALUATION ANSWER ALL QUESTIONS

HAS THE INDIVIDUAL HAD AN INTERVIEW WITH USCIS AT ANY TIME? YES  NO  **IF YES, PLEASE FAX/MAIL USCIS FORM(S) AS SOON POSSIBLE.**  
 DID THE INDIVIDUAL ATTENDED SCHOOL AS A CHILD? YES  NO  **IF YES, HOW MANY YEARS?** \_\_\_\_\_  
 HAS THE INDIVIDUAL HAD A CONCUSSION OR HEAD INJURY? YES  NO  **IF YES, WHEN** \_\_\_\_\_  
 HAS THE INDIVIDUAL HAD A STROKE/NEUROLOGICAL EVENT? YES  NO  **IF YES, WHEN** \_\_\_\_\_  
 CAN THE INDIVIDUAL READ AT AN ADULT LEVEL IN THEIR LANGUAGE? YES  NO   
 CAN THE INDIVIDUAL WRITE AT AN ADULT LEVEL IN THEIR LANGUAGE? YES  NO   
 DOES THE INDIVIDUAL OR FAMILY THINK THE INDIVIDUAL HAS MEMORY PROBLEMS OR FROGETFULNESS? YES  NO  **IF YES, HOW LONG** \_\_\_\_\_

**PLEASE FAX OR EMAIL THIS COMPLETED FORM TO DR. SIGLER USING THE CONTACT INFORMATION BELOW**

1935 CTY RD B2 W STE 270 • ROSEVILLE • MN • 55113-2785 • CELL PHONE 612-688-1909 • FAX 612-392-0400

[WWW.DIVERSEASSESSMENST.ORG](http://WWW.DIVERSEASSESSMENST.ORG) • [TODD@DIVERSEASSESSMENTS.ORG](mailto:TODD@DIVERSEASSESSMENTS.ORG)