NEW PATIENT REFERRAL WORKSHEET

MAURICE SMITH, PHD, LP • DIVERSE ASSESSMENTS & TREATMENT, LLC

REASON FOR THE REFERRAL FOR PSYCHOLOGICAL SERVICES?

☒	*SERVICE REQUESTED*	*EXAMPLES*	*INSURANCE?*
☐	ASSESSMENT FOR TREATMENT & SERVICE PLANNING	Rule 185, Rule 79, CADI, DD, ASD, etc.	***YES***
☐	TO ASSESS AN ATTENTIONAL PROBLEM	ADHD, etc.	***YES***
☐	TO ASSESS FOR AUTISM SPECTRUM DISORDER	Adolescent and Adult Assessments	***YES***
☐	APPEAL A SOCIAL SECURITY DISABILITY	Social Security Hearing/Appeal	***NO***
☐	COMPREHENSIVE COGNITIVE/INTELLECTUAL, ADAPTIVE FUNC., AND PERSONALITY EVAL.	Requested by Therapist/Other Professional	***YES***
☐	_____	_____	***TBD***
☐	_____	_____	***TBD***
☐	_____	_____	***TBD***

PATIENT CONTACT INFORMATION

FIRST NAME: _____ LAST NAME: _____

GENDER: _____ DATE OF BIRTH: _____ PRIMARY PHONE #: _____

EMAIL: _____ RACE/ETHNICITY: _____ LANGUAGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT INFORMATION FOR SCHEDULING APPOINTMENT & FOLLOW UP

WHO SHOULD I CONTACT TO SCHEDULE?: _____ RELATIONSHIP: _____

EMAIL: _____ CELL ☐ /TEXT ☐ /HOME ☐: _____

OK TO LEAVE MESSAGES? (CHECK ALL THAT APPLY): HOME ☐ CELL ☐ TEXT MSG ☐ EMAIL ☐ ALL ☐

REFERRAL AGENT INFORMATION

REFERRING AGENT (NAME/AGENCY): _____

ADDRESS: _____

FAX: _____ PHONE: _____ EMAIL: _____

BACKGROUND AND MEDICAL INFORMATION

CURRENT DIAGNOSES: _____ ☐ (OR ATTACH RECORDS)

CURRENT MEDICATIONS: _____ ☐ (OR ATTACH RECORDS)

PRIMARY CARE PROVIDER: _____ ☐ (OR ATTACH RECORDS)

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ ID#: _____ GROUP #: _____

SECONDARY INSURANCE NAME: _____ ID#: _____ GROUP #: _____

PATIENTS REQUIRING AN INTERPRETER

LANGUAGE: _____ GENDER PREFERENCE? MALE: ☐ FEMALE: ☐ NO PREFERENCE: ☐

SOCIAL SECURITY #: _____ PERMANENT RESIDENT #: A-_____ BIRTH COUNTRY: _____