DIVERSE ASSESSMENTS & TREATMENT, LLC

TODD M. SIGLER, PSYD, LP, NCC

USE THIS FORM TO REQUEST A PSYCHOLOGICAL EVALUATION FOR AN 6-YEAR TO 17-YEAR-OLD WHO IS NONVERBAL, MINIMALLY VERBAL OR AN ENGLISH LANGUAGE LEARNER (ELL)

ARE YOU REQUESTING A PSYCHOLOGICAL EVALUATION FOR AN 6-YEAR-OLD TO 17-YEAR-OLD WHO IS: 1) **NONVERBAL**, 2) **MINIMALLY VERBAL**, OR 3) AN **ENGLISH LANGUAGE LEARNER** (ELL)?

___ **YES. COMPLETE THIS FORM.** ___ **NO. Dr. Sigler does not assess VERBAL *6- to 17-year-olds.***

NAVIGATE TO CLINIC WEB PAGE BY CLICKING _____

PROSPECTIVE PATIENT INFORMATION

LEGAL FIRST NAME _____

LEGAL MIDDLE NAME _____

LEGAL LAST NAME _____

PREFERRED NAME _____

DATE OF BIRTH _____

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) _____

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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 COMPANY _____

PRIMARY INSURACNE ID# _____ PRIMARY GROUP # _____

SECONDARY INSURANCE COMPANY (IF ANY) _____

SECONDARY 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 NEEDED.

WHAT LANGUAGE SHOULD THE INTERPRETER SPEAK? _____

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

PLEASE ADD ANY ADDITIONAL INFORMATION ABOUT THE PROSPECTIVE PATIENT.

_____

_____

_____