PSYCHOLOGICAL ASSESSMENT
REFERRAL FORM

Serenity Circle COUNSELING

PLEASE TYPE AND BE SPECIFIC AS POSSIBLE AS TO WHY YOU, THE REFERRING CLINICIAN, ARE REQUESTING A PSYCHOLOGICAL ASSESSMENT. THIS FORM WILL BE SENT WITH THE PRIOR-AUTH REQUEST. YOUR INFORMATION WILL HELP THE INSURANCE DETERMINE IF THE ASSESSMENT IS MEDICALLY NECESSARY.

REFERRAL SOURCE	
Agency:	Agency Location:
Form Completed By:	Your Contact Phone Number:

CLIENT INFO	
Name:	DOB:
Address:	Phone number:
Parent/Guardian name (If applicable):	Parent/Guardian Phone #:
Health ins company:	Insurance ID:
Current Diagnoses:	Rule out Diagnosis:
Any current safety concerns:	If yes, please describe:
Relevant medical conditions:	Psychosocial and environmental problems:

REASON FOR TESTING

What clinical question(s) would you like answered by psychological testing that cannot be answered through comprehensive diagnostic interview? **Please include a description of clinical symptoms and functional impairment.** Please also include information about any testing completed previously. Attach additional pages if necessary.

APPROPRIATE REFERRAL	REFER OUT
• Diagnostic clarification/differential diagnosis • ADHD assessments • Providing treatment recommendations for those clients that you might feel have hit a barrier in their therapeutic journey. • Diagnostic clarification: ages 9+ • Autism assessments/diagnosis (ages 6+)	• Neuropsychological testing • Any assessments for young children (unless meets criteria on the left)

PLEASE SEND THE MOST RECENT DIAGNOSTIC ASSESSMENT AND CLINICAL DIAGNOSTIC SUMMARY IF THERE ARE ADDITIONAL SYMPTOMS TO REPORT THAT WILL BE HELPFUL FOR THE EVALUATION.

PLEASE SEND A SIGNED ROI WITH REFERRAL IF APPLICABLE

PLEASE FAX COMPLETED FORM TO: 763-244-1243

REFERRAL DOES NOT GUARANTEE A CURRENT OPENING. WE WILL DO OUR BEST TO GET NEW CLIENTS IN.