KidsCare Psychological Services, PLLC

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Psychological Services Referral Form

Referral Date: _____ Referral Phone: _____

Referral Fax: _____

Referral Source (Name and Agency):_____

Referral Address: _____

Patient Information

Patient's Full Name: _____ DOB: _____

Gender: _____ Race/ Ethnicity:_____

Address: _____

Phone Number: _____ Alt. Phone Number: _____

Email (ages 18 and up only): _____

Parent/ Guardian Information (if applicable)

Name: _____ Relationship to Patient: _____

Address: _____

Phone: _____ Email: _____

_____

Best time(s) to contact: _____

Insurance Information

Primary Insurance: _____ Member ID: _____

Policy Holder Name: _____ Relationship to Patient: _____

Secondary Insurance (if applicable):_____

Policy Holder Name: _____ Member ID: _____

Presenting Concerns

Please list the patient's main concerns and previous diagnoses (if known):

_____

_____

_____

_____

Referral Services Requested (check all that apply):

- ☐ Autism Diagnostic Exam
- ☐ Psychological evaluation (e.g., IQ, achievement, personality, etc.)
- ☐ AD/HD Assessment
- ☐ Behavior Assessment
- ☐ Therapy

Has the patient received any inpatient or outpatient mental health treatment? If yes, please provide the name of the agency and/ or provider.

_____

_____

_____

Please list any previous psychological testing (provider name and agency):

_____

_____

Please list current prescribed psychotropic medications:

_____

_____

Does the patient have any trauma history? If yes, please briefly explain.

_____