Family PsychSolutions Psychological Testing Services Referral Form

CLIENT DEMOGRAPHICS:

Name: _____ **DOB : _____**

Address: _____ **Phone: _____**

_____ **Alt. Phone: _____**

If a minor:
Caregiver Name: _____

Lives with ❑ Family ❑ Foster Family

SERVICES REQUESTED:
❑IQ ❑Academics ❑Emotional Functioning ❑Behavioral Functioning

Explain reason for testing:_____

_____

CLINICAL SYMPTOMS:

❑ Depression	❑ Anger	❑ Anxiety
❑ Behavior Problems	❑ Learning Difficulties	❑ Drug / Alcohol Abuse
❑ Divorce Adjustment Issues	❑ Legal/Juvenile Justice	❑ Other Adjustment Issues/Foster care
❑ Poor Self Esteem	❑ ADHD	❑ Family Conflict
❑ Loss / Grief	❑ Fights / Temper Tantrums	❑ Trauma

Currently seeing a therapist? ❑yes ❑no If yes, for how long? _____

Name and phone number of therapist _____

Current diagnoses if known _____

Date of last psychological evaluation_____
Please fax last psychological evaluation with referral form

Current Medications: _____

REFERRAL SOURCE:
Name of person making referral: _____

Agency: _____

Phone: _____ Fax: _____