AMPERS&ND
Psychological Services

Date: ☐

REFERRAL FORM

CLIENT INFORMATION

Name: _____

Legal Guardian (if applicable): _____

Address: _____

Phone: _____

Email: _____

Date of Birth: _____

Insurance Provider: _____

Insurance ID Number: _____

Insurance Group Number: _____

REFERRAL SOURCE

Name: _____

Organization: _____

Address: _____

Phone: _____

Email: _____

Fax: _____

Reason for Referral (Check all that apply):	**Presenting Concerns (Check all that apply):**
☐ Diagnostic Assessment ☐ Mental Health Therapy ☐ EMDR ☐ Psychological Testing ☐ Assist with diagnosis ☐ Assist with specific differential ☐ Evaluate current functioning ☐ Legal/decisional capacity ☐ Assess for impacts of psychological factors ☐ Establish a cognitive baseline ☐ Compare to prior eval, assess change ☐ Parenting Assessment ☐ Psychological only (e.g., mood/personality) ☐ Psychosexual evaluation ☐ Other: _____	☐ Serious Mental Illness ☐ Suicidal Thoughts/Behaviors ☐ Self-Harm ☐ Substance Use ☐ Abuse/Trauma ☐ Cognitive (memory, attention, processing, executive functions) ☐ Psychological (depression, anxiety, personality change) ☐ Other:_____
Additional Information:	

Provider Check-List:

- ☐ *Complete and send release(s) of Information*
- ☐ *Provide recent Diagnostic Assessments and/or Testing*
- ☐ *Send via secure email, fax, or mail*