EUNOIA
FAMILY RESOURCE CENTER, PA

1420 N. State Street
Fairmont, MN 56031
Phone: 507-235-6070
Fax: 855-847-9876

Psychological/Neuropsychological Testing Referral Form

Date of Referral: _____ Date Clinical Information is Needed: _____

Client Information

Name: _____ DOB: _____

Sex: ☐ Male ☐ Female Address: _____

Phone Number: _____ _____
Home/Cell/Work/Other City, State, Zip Code

Okay to Leave Msg/Contact about Appt.? – Y / N If minor, who has legal custody:_____

Information needed prior to evaluation (indicate what sources may have information):

__ Medical case: _____
__ Mental health: _____
__ Education: _____
__ Social service: _____
__ Legal: _____

Reason for referral:

What questions need to be answered that cannot be answered without a psychological evaluation?

☐ ADHD Simple Assessment: Does the person I am referring have ADD, ADHD, attention problems, Sluggish Cognitive Tempo (SCT)?

☐ ADHD Complex Assessment (needed when a diagnosis may already exist and current treatment proves to be ineffective): Does the person I am referring have ADD, ADHD, attention problems, Sluggish Cognitive Tempo (SCT) with added executive dysfunction/executive functioning disorder questions? Executive functions include planning, problem solving, response inhibition, self-control, self-regulation (thoughts, behaviors and emotions).

☐ ID Assessment (also known as a Comprehensive Rule 185 assessment; formerly known as MR): Does the person I am referring have an intellectual disability (mental retardation)?

☐ LD Assessment: Does the person I am referring have a learning disorder, a reading disorder, dyslexia, math disorder, dyscalculia, writing disorder, dysgraphia, or a specific learning disorder?

☐ Memory/Dementia Assessment: Does the person I am referring have concerns about their memory or have trouble remembering things? Does the person I am referring have dementia, Alzheimer's, Fronto-Temporal Dementia (FTD), pseudodementia (a.k.a. depression), some other form of dementia or memory impairment (i.e., Mild Cognitive Impairment – MCI, etc.)?

☐ Diagnostic Clarification/Personality Assessment: Does the person I am referring have bipolar, BPD, PTSD, psychosis/schizophrenia? Why do this person's relationships fail? Why does this person do certain things?

☐ Pre-surgical/Bariatric Assessment: The referred person's doctor or insurance company said this is necessary for surgery. Can this person get bariatric/gastric bypass/sleeve surgery?

☐ Pre-surgical/Spinal Stimulator/Pain Assessment: The referred person's doctor or insurance company said this is necessary for surgery. Can this person get a spinal stimulator?

☐ Other: _____

_____

_____

_____

Specify question(s) for which clinical information is requested:

_____
_____
_____
_____
_____

Why is the information being requested at this time? (e.g., what events, problems, changes, or new circumstances give rise to the request now? What is the history of the difficulties?):_____
_____
_____
_____
_____

Has previous testing been done? Y / N If so, where, for what, and when: _____
_____

Have other sources been consulted to determine if a psychological evaluation is required vs. other ways to answer the questions being asked?:

_____
_____
_____
_____

Referral Source Information (Please include a signed release of information if we need to contact you.)

_____ _____
Name Organization

_____ _____
Address Phone Number

_____ _____
City, State, Zip Code Fax Number

All information provided is confidential and will be inaccessible to anyone without a release of information and permission to do so.

Funding:

Is the Assessment Court Ordered? ☐ Yes (Please provide court order and payment source) ☐ No

Is Medical Insurance Available? - Y / N
If yes, please provide insurance information (if available) and a copy of insurance cards (if available):

Primary Company:_____ ID:_____

Policy Holder and DOB: _____

Ins. Co. Phone # _____ Group: _____

Secondary Company: _____ ID: _____

Policy Holder and DOB:_____

Ins. Co. Phone #: _____ Group: _____

If no, is another agency or entity (e.g., third party) paying for services? – Y / N
If yes, please provide the payer's name, phone and address to which this client's bill(s) will be sent:

Name: _____ Phone: _____

Address: _____

Authorization of Third-Party Payment (this must be signed prior to Eunoia providing services):

I hereby authorize payment for the services indicated above.

_____

Signature Print Name Date

Contact Information: _____

If no, is the client responsible for the cost of services? – Y / N
If yes, the client will be responsible for paying the cost of testing up front.

Please complete and submit to:

Eunoia Family Resource Center
1420 N. State Street
Fairmont, MN 56031
Fax: 855-847-9876

****Please remember to include all documentation available (including DAs, progress notes, previous testing, social services, etc.).**

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