



PLEASE NOTE, WE DO NOT PROVIDE PSYCHIATRIC SERVICES OR BEHAVIORAL THERAPY.
Current wait time for an evaluation is more than 9 months. Please have the parent initiate an evaluation through the school district. Also, refer out for speech & OT if delays are suspected.

Date requested: ____ / ____ / ____

Patient Information

Patient Name: _____ DOB: _____ Male Female
 Responsible Party (Mother/Father/Other) : _____
 Patient's Address: _____ City/State/Zip: _____
 Best Contact Number: _____ Alternate Contact Number: _____
 Interpreter Required? Yes No Language: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____
 Subscriber's Name: _____ Subscriber's Name: _____
 ID #: _____ Group #: _____ ID #: _____ Group #: _____

Reason for Referral

Treatment goals may be obtained within a few visits. In those cases, the patient will be transitioned back to PCP to resume care.

Service Request

CONSULTATION WITH PSYCHOLOGIST

Please note:

- Referral age is toddler to 12 years old.
- The only Medicaid Insurance accepted are Driscoll Health Plan and TMHP Medicaid. All other private insurance is Out of Network.
- All services are only for short term.

For suspected but not yet diagnosed referral for autism, require screening results for autism. Exp. - (MCHAT,ASQ or CAST)

CHECK ALL THAT APPLY:

- Learning Disabilities
- Autism Spectrum Disorders
- ADD, ADHD and Disruptive Behaviors
- Developmental Delay
- Anxiety and Depression
- Psychologist evaluation with IQ, cognitive, academic, language and autism testing

Suspected Diagnosis: _____

Referring Practice Information

Referring Provider Name (Please Print Legibly): _____
 Practice Name: _____ Practice #: _____
 Address: _____ Telephone: _____ Fax: _____
 Medicaid PA good for _____ visits. Valid through _____ (Date) _____

Please include demographics info, copy of insurance (both sides) & current clinicals and medication list.