Request for Psychological Assessment

I. Client Demographics

Today's Date: _____
Client Name: _____ Date of Birth: _____
Parent's Names (if client is a minor): _____
Address: _____ Phone: _____
Does Client have a Guardian: YES___ NO___ Name: _____
Guardians Address: _____Phone: _____
Insurance Carrier: _____ Policy #: _____

II. Person or Agency Making Referral for Testing:
Name and Credentials: _____
Agency : _____

III. Current DSM-5/ICD-10 Diagnosis (code and diagnosis name:

1. _____
2. _____
3. _____
4. _____

IV. Give the ***SPECIFIC*** reason for testing (i.e., Learning Disability, autism, IQ, ADHD):

_____
_____

V. What are the current symptoms related to these questions:

_____
_____

VI. Medical/Psychological Evaluation and Treatment History:

1. Has the client had a diagnostic interview? Yes No If yes, date of interview: _____
2. Has the client had a psychiatric evaluation? Yes No If yes, date of interview: _____
3. Has the client had previous psychological testing? Yes No If yes, date of testing: _____
4. Current Psychotropic Medications:
   _____
   _____

VII. Barriers to Standard Assessment:

1. Does the client have a verbal, physical, visual, or auditory impairment? Yes No
   a. If yes, please elaborate: _____
2. Is the client actively using/abusing any substance? Yes No
   a. If yes, please elaborate: _____