REFERRAL FOR PSYCHOLOGICAL TESTING

What areas of the client's personality, functioning, symptoms, or diagnosis would you like to have investigated via psychological testing?

How do you hope that psychological testing will help you with this client's treatment or care?

Are there other methods that could achieve the same result, such as consultation with another provider, getting past records of the client, etc.? ☐ Yes ☐ No

If the person who will do the testing is not in the same location as the client's chart, please describe the client's primary language, current medications, eyesight or hearing limitations, and any recent significant stressors or traumas.

Has the client had previous psychological testing? Where and dates? Are the reports available to us?

Telephone where client may be contacted (and parent's or guardian's name if client is a child)--

Person Requesting Testing | Clinic | Date

(Route form to clinic lead psychologist or psychologist to do testing. Chart why if testing not done.)

PSYCHOLOGICAL TESTING REFERRAL
SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Info.
See W&I Code 5328

NAME:

CHART NO:

DOB:

PROGRAM: