# County of San Bernardino Department of Behavioral Health
## Psychological Testing Referral Form
**Send completed form to: internprograms@dbh.sbcounty.gov**

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|---|---|
| **Type of testing requested?** | |
| **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 a consultation with another provider, getting past records of the client, etc?** | No<br>Yes |
| **Has the client had previous psychological testing?** | No<br>Yes<br>If yes, where and dates?<br>Are the reports available to us? No Yes |

| **Patient Demographics** | |
|---|---|
| **Primary language:** | |
| **Current medications:** | |
| **Eyesight or hearing limitations:** | |
| **Recent stressors or trauma:** | |

| **Person Requesting Testing** | | **Date** | |
|---|---|---|---|

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|---|---|
| **Parent/Guardian Name(s), as applicable:** | |
| **Client telephone(s):** | |
| **Comments/Notes:** | |

**Psychological Testing Referral County of San Bernardino Department of Behavioral Health Confidential Patient Information See W&I Code 5328**

| | |
|---|---|
| NAME: | |
| CHART NO: | |
| DOB: | |
| PROGRAM: | |