WELLHOME PSYCHOLOGY
Home- and Community-based Therapies

PSYCHOLOGICAL TESTING REFERRAL FORM (EXTERNAL)

Thank you for referring a patient to WellHome Psychology for psychological or neurodevelopmental evaluation. This form helps us understand the referral question and coordinate care efficiently.

[Please complete as fully as possible and return with any relevant records.]

Referring Provider Information

PROVIDER NAME: _____

PRACTICE / ORGANIZATION: _____

ADDRESS: _____

PHONE: _____ **EMAIL:** _____

FAX: _____ **REFERRAL DATE:** _____

Patient Information

PATIENT NAME: _____

PARENT/GUARDIAN (if applicable): _____

DOB (MM/DD/YY): _____ **Preferred Contact (circle) : Phone / Email**

PHONE: _____ **EMAIL:** _____

Reason for Referral (check all that apply):

Please note: PLEASE INDICATE TYPE OF TESTING/EVALUATION NEEDED (IF KNOWN).	
☐ Attention-Deficit/Hyperactivity Disorder (ADHD)	☐ Trauma vs neurodevelopmental differential
☐ Autism Spectrum Disorder (ASD)	☐ Mood or anxiety diagnostic clarification
☐ Executive functioning concerns	☐ Academic/testing accommodations documentation
☐ Learning and processing differences	☐ Other (please specify):

Primary Referral Question for Referral

Please describe the primary diagnostic or clinical question prompting this referral.

_____

_____

_____

_____

Relevant Clinical History

☐ Prior diagnoses (please list):

_____

_____

_____

☐ Current medications:

_____

_____

_____

☐ History of trauma or significant stressors (if known):

_____

_____

☐ Prior psychological or neuropsychological testing (attach if available):

_____

_____

Current Concerns / Observations

Please describe current symptoms, functional impairment, or concerns observed:

_____

_____

_____

_____

_____

_____

Insurance & Payment Information

Please note: All evaluations at WellHome Psychology are self-pay.
Does the patient understand this?
☐ Yes ☐ No

Release & Coordination of Care

Has the patient provided consent for communication regarding this referral?
☐ Yes ☐ No

If yes, preferred method for feedback:
☐ Written report
☐ Phone consultation
☐ Secure email (if authorized)

_____ _____

Referring Provider Signature Date