

REFERRAL FOR PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING

Palmetto Psychological is not in network with any insurance plan. Some insurance plans will reimburse clients for fees paid to out of network providers for *medically necessary* evaluations.

FROM

Referring Provider	Phone
Referring Provider's Signature	Date

**PATIENT
INFORMATION**

Last Name	First Name	Middle Initial
Date of Birth	Phone	

If the Patient is a minor, _____
Name of Parent(s)/Guardian(s)

REFERRAL INFORMATION

- Yes No **Has the patient had previous neuropsychological or psychological testing?**
- Yes No **Has the patient had previous educational testing and/or receives/d specialized instruction or intervention (BabyNet) services?**
- Yes No **Has the patient the patient been previously diagnosed with a neurodevelopmental disorder (ASD, ADHD, SLD, dyslexia, ID, etc.?)**
Please specify: _____

Please indicate your reason(s) for referring this patient:

- Developmental delays**
 - Cognitive Communication Motor Skills Socialization
- Testing for autism spectrum disorder**
- Testing for attention-deficit/hyperactivity disorder**
- Testing for learning problems**
 - Reading Written Expression Mathematics
- Concern(s) for social, emotional or behavioral functioning**
Please specify: _____
- Re-evaluation to determine present levels of functioning**
- Other.** Please specify: _____

Please submit form by fax to 864-529-9833 or email to referrals@palmettopsy.com

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