REFERRAL FORM – PSYCHOLOGICAL SERVICES

Spectrus Psychological Services, Corp.
Phone: 940-205-8335 | Fax: 866-899-7939
info@spectruspsych.com | www.spectruspsych.com

REFERRING PROVIDER INFORMATION

Referring Provider Name: _____

Credentials (MD, DO, NP, PA, LPC, LCSW, etc.): _____

Practice / Organization Name: _____

Phone: _____ Fax: _____

Secure Email: _____

Practice Address:

_____

_____

PATIENT INFORMATION

Patient Full Legal Name: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Legal Guardian (if applicable): _____

Patient Phone: _____

Patient Email: _____

Preferred Method of Contact:

☐ Phone ☐ Email ☐ Either

INSURANCE INFORMATION

Insurance Carrier: _____

Policy Holder Name: _____

Member ID: _____

☐ Self-Pay / No Insurance Billing Requested

TYPE OF SERVICES REQUESTED

THERAPY SERVICES

☐ Individual Therapy

☐ Couples Therapy

☐ Family Therapy

☐ Child / Adolescent Therapy

☐ Trauma-Focused Therapy

☐ Anxiety / Mood-Related Concerns

☐ Behavioral / Emotional Regulation

☐ Other: _____

PSYCHOLOGICAL / NEUROPSYCHOLOGICAL TESTING

☐ Diagnostic Clarification

☐ ADHD / Attention Evaluation

☐ Autism Spectrum Evaluation

☐ Learning / Academic Concerns

☐ Emotional / Personality Assessment

☐ Trauma / Dissociation Assessment

☐ Cognitive / Neuropsychological Evaluation

☐ Other: _____

CLINICAL INFORMATION

Presenting Concerns / Symptoms:

_____

_____

_____

Relevant Diagnoses (if known):

_____

Current Medications (if applicable):

_____

RISK / SAFETY CONSIDERATIONS

☐ None reported

☐ History of self-harm

☐ Current or past suicidal ideation

☐ Aggression or safety concerns

☐ Other (explain): _____

REFERRAL DETAILS

Primary Reason for Referral / Questions to Be Addressed:

_____

_____

_____

Time Sensitivity:

☐ Routine

☐ Urgent (explain): _____

RECORDS ATTACHED

☐ Clinical notes

☐ Prior psychological evaluations

☐ Medical records

☐ Treatment summaries

☐ School records / IEP / 504

☐ Other: _____

AUTHORIZATION

I confirm that the patient or legal guardian has consented to this referral and the release of relevant clinical information for coordination of care.

Referring Provider/Staff Signature: _____

Date (MM/DD/YYYY): _____

SUBMISSION INSTRUCTIONS

This form contains protected health information (PHI). Please submit by attaching this and any supporting documents via our Secure Email or secure fax at 866-899-7939. Do not send via unencrypted email.