Referral for Psychological Assessment

With Dr. Justin Gambill, PsyD, LP

Date: ________________

Person Making the Referral: ____
Relationship to Client: ____
Contact (phone/email): ____

Client Name: ______________________ Birth Gender: *Male / Female* DOB: __________
School: ______________ Grade: _____ IEP: *Yes / No* If yes, qualifying disability: ______________

Mental/Behavioral Health Diagnoses: ____
____

Current Providers (e.g., therapist, medication manager, CTSS/ARMHS worker, case manager, probation officer, PT/OT/Speech, PCA): ____

Prior Assessments - Please provide DATE (exact or approximate) and NAME and AGENCY:

- Diagnostic Assessment: ____
- Psychological Assessment: ____
- Neuropsychological Assessment: ____
- Other (e.g., Speech, PT, OT): ____

Limitations (e.g., physical disability, vision/hearing impairment, language/mute): ______________________

Parent/Guardian Name (If applicable): ____
Client or Parent/Guardian Address: ____
Client or Parent/Guardian Phone: ____

*****REASON FOR REFERRAL** (i.e., What are the concerns? What do you want investigated? What are you hoping to obtain/receive from this assessment?)