Counseling Services of Southern Minnesota

PROFESSIONAL REFERRAL FORM FOR PSYCHOLOGICAL ASSESSMENT

REFERRAL Source Information:

Name: _____ Role:_____
County/Agency/Clinic: _____
Phone: _____
Fax: _____
E-mail: _____

PATIENT Information:

Patient Name: _____
Date of Birth: _____
Parent/Guardian Name(s): _____
Phone Number(s): _____

CURRENT EDUCATION CATEGORY FROM SCHOOL EVALUATION (FOR INDIVIDUALS 21 AND YOUNGER):

CURRENT MEDICAL/MENTAL HEALTH DIAGNOSES (INCLUDING PROVISIONAL/RULE OUT DIAGNOSES):

Counseling Services
of Southern Minnesota

CURRENT SERVICE PROVIDERS (MEDICAL, MENTAL HEALTH, LEGAL, ETC.):

PRESENTING PROBLEM/CURRENT SYMPTOMS/Brief Explanation:

AS A RESULT OF THIS EVALUATION I WOULD LIKE TO LEARN:

Thank you for your referral. Please complete the form and fax to: Attn Intake Dept 507-931-8060. Any additional questions can be directed to the Intake Dept at 507-931-8040.