Multicultural Institute for Development

Psychological Testing Referral Form

Note to Client: *This form should be filled out by your referring provider (MD, therapist, school IEP team, disability office, etc.) with you. You can use this form or have your provider write a letter with the information.* ***It requires your signature as well as the referring providers information.***

Client Name: _____

DOB: _____ **Gender:** _____

Phone: _____ **Email:** _____

Parent/Guardian Name (if applicable): _____

Relationship to Client: _____ **Phone:** _____

1. Referring Party Information

- Name: _____
- Role/Title: _____
- Agency/School/Practice: _____
- Phone: _____

2. Reason for Referral

(Please provide a brief, bulleted description of the concerns, symptoms, behaviors, or circumstances prompting this referral. Include relevant history, observed patterns, and any specific questions you would like the evaluation to address.)

Client Name:_____

3. Areas to Assess *(Check all that apply — final assessment scope will be determined by the evaluating clinician based on professional judgment.)*

☐ Attention / Executive Functioning
☐ Memory / Learning & Retention
☐ Academic Skills (Reading / Writing / Math)
☐ Processing Speed
☐ Social / Emotional/ Behavioral
☐ Adaptive / Daily Living Skills
☐ Personality
☐ Other: _____

For each area checked above, please briefly explain why you would like it evaluated and how the information will be used.

4. Purpose of Testing / Intended Use of Results *(Check all that apply)*

☐ Diagnostic Clarification
☐ Educational Accommodations (504/IEP)
☐ Treatment Planning
☐ Disability Benefits / Insurance
☐ Legal Proceedings
☐ Vocational / Employment Planning
☐ Other/Describe:

_____

5. Previous Testing History

☐ No prior testing
☐ Yes — please provide details (Clients must bring copies to first session if available):

Type of testing/Provider/Dates

7. Functional / Access Considerations

Primary language: _____

English fluency: ☐ Fluent ☐ Limited

Need for interpreter: ☐ No ☐ Yes (explain): _____

Vision impairment: ☐ No ☐ Yes (explain): _____

Hearing impairment: ☐ No ☐ Yes (explain): _____

Mobility needs or other accommodations: _____

8. Authorization to Exchange Information

I hereby authorize OMID to communicate and exchange relevant health, educational, and/or psychological information with the referring provider identified above. *This exchange is for the sole purpose of coordinating and conducting psychological testing, interpreting results, and making treatment or educational recommendations. This authorization is voluntary, remains in effect for twelve (12) months from the date signed unless revoked in writing, and may be withdrawn at any time by providing written notice to OMID. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy regulations.*

Client/Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

9. Referring Professional Confirmation

I confirm that I am referring the above-named individual for psychological testing based on my professional assessment of need. I have provided accurate and complete information to the best of my knowledge and agree to collaborate with ***OMID*** *in the coordination of care as appropriate.*

Signature: _____ Date: _____

Printed Name: _____

Role/Title(License # if applicable): _____