MOUNTAINEER
PSYCHOLOGICAL SERVICES

Referral Form—Evaluation

Date: _____/_____/_______

Patient Name: ____

Referral Source: ____

Referral Source Contact Information: ____

Relation to Patient: ____

Agency: WV DHHR Probation CPS Other: ____

Patient Date of Birth: _____/______/______ **Sex: M / F** **Age:** _______

FACTS Client ID #: ____

Social Security Number:________________________ **Medicaid ID Number:** ___________________________

Patient mailing address: ____

Is this evaluation court-ordered? Y / N **If yes, please provide a copy of the court order with the referral form**

Next Court Date (Or timeframe for when report is needed): ____

Purpose of the Evaluation? (What question(s) are to be answered via the evaluation?)

____

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____

____

Please briefly describe the patient's presenting concern(s): Abuse/Neglect Truancy Substance Abuse Parental Fitness Other: ____

Please describe the details of the presenting concerns:____

____

____

____

What Records are Available?____

____

Please send any available records to office@mountaineerpsyc.com prior to the evaluation

Patient Information:

Previous mental health treatment? Y / N **Previous Evaluations? Y / N**

Please describe: ____

____

____

Any current mental health treatment or medications? Y / N

____

____

Prior hospitalizations for mental health reasons? (If yes, please list approximate dates and reasons):

____

____

Any significant medical issues or medications at this time? Y / N

____

____

Any current/pending legal charges? Y / N ____

____

Does the person have any limitations (e.g., literacy issues, communication problems, physical disabilities, etc.) which might need to be considered for the evaluation? Y / N

Please Describe: ____

Contact Person (if not patient):____

Relation to patient:____

Mailing address:____

____

____

Best telephone number: ______________________________ **Is this a mobile / home / work line?**

Alternative Number: ___________________________________ mobile / home / work line

Email address: ____

Who will pay for evaluation? ____

***If WV Medicaid, we will need both the Medicaid ID and the Patient SSN before the evaluation can be scheduled; If Special Letter, we will need to have the letter before the evaluation will be scheduled.**

Primary Insurance Carrier:

____

Policy Number:____

Group Number:____

Medicaid ID: ____

Policy Holder's Name, Date of Birth, and Social Security number, Relation to Patient:

____

____

Any other pertinent information:

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Thank You for Your Referrals!

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