



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: _____

Social Security Number: _____ Medicaid ID Number: _____

Patient mailing address: _____

Patient telephone number: _____ Is this a mobile / home / work line?

Email 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 EVALUATION? (What question(s) are to be answered via the evaluation?)

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: _____

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/email address (Contact person):

Contact person telephone number: _____ Is this a mobile / home / work line?

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 Court Ordered, we will need to have the order 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:

Thank you for your referral!!