PINEYWOODS
PSYCHOLOGICAL SERVICES

Referred By (provider name)**:** _____ **Date:** _____

Medical Practice Name: _____ **Phone#:** _____

Office Contact Person: _____ **Fax#:** _____

Patient & Insurance Information:

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian (if applicable): _____ **Phone #:** (____) _____

Primary Insurance: _____ **Subscriber Name:** _____

Patient Referred for: (check one or more boxes below)

- ☐ **Psychological Testing for ADHD**
- ☐ **Psychological Testing for Learning Disability**
- ☐ **Psychological Testing for Autism**
- ☐ **Cognitive Testing for Cognitive Disorder**
- ☐ **Presurgical Testing** *(gastric bypass, spinal cord implant, etc)*
- ☐ **Monitoring progress with medication** *(ex: ADHD following trial of psychostimulant)*
- ☐ **Other assessment:** _____

Patient's Release of Information: ***I authorize my doctor's office to share this form with Pineywoods Psychological Services for the purpose of discussing and scheduling my appointment.***

Patient signature: _____ Date: _____

☐ Please check box if patient provided verbal consent.

Please fax this form to 936-228-907 or call 936-462-8577. Our staff will call the patient within two business days. If urgent, please call office. If actively suicidal, please refer to emergency services and/or Burke.