MINNESOTA PSYCHOLOGICAL TESTING REFERRAL FORM

Date:_____

1. Referent Information **Please note that we only accept psychological testing referrals from healthcare organizations.*

Full Name of Individual Completing Referral Form: _____

Referring Provider's Full Name & Credentials: _____

Referent Organization: _____ Referent Phone: _____

Referent Email: _____ Referent Fax: _____

Referent Street Address: _____

City: _____ State: _____ Zip Code: _____

2. Patient Information

Patient First Name: _____ Patient Middle Initial___ Patient Last Name: _____

Patient Date of Birth: _____ Patient Sex: _____ Patient Gender: _____

Patient Phone: _____ Patient Email: _____

Legal Guardian Name (if applicable): _____

Patient Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Primary language: _____ Is an interpreter needed? _____

3. Referral Details

Location: [select all that apply] **Please note these are the only locations that currently offer psychological testing in Minnesota*

- ☐ Apple Valley, MN
- ☐ Big Lake, MN
- ☐ Bloomington, MN
- ☐ Coon Rapids, MN
- ☐ Cottage Grove, MN
- ☐ Duluth, MN
- ☐ Eden Prairie, MN
- ☐ Edina, MN
- ☐ Lakeville, MN
- ☐ Maple Grove, MN
- ☐ Minnetonka, MN
- ☐ Moorhead, MN
- ☐ New Brighton, MN
- ☐ Otsego, MN
- ☐ Rochester, MN
- ☐ St. Cloud, MN
- ☐ Woodbury, MN
- ☐ Any location in MN

Reason for Referral: [select all that apply]

- ☐ ADD/ADHD Testing
- ☐ Autism Testing
- ☐ Bariatric Evaluation
- ☐ Disability Evaluation (does not include forms)
- ☐ Disability Evaluation with Forms (forms must be attached)
- ☐ Emotional/Behavioral/Personality Concerns
- ☐ IQ/Intellectual Disability/Adaptive Functioning
- ☐ Learning Concerns
- ☐ Neuropsychological Testing
  - Significant cognitive learning/development/memory concerns
- ☐ Other: _____

Is the Referral Court Ordered ☐ Yes ☐ No

Has the patient been previously diagnosed with Autism? ☐ Yes ☐ No

Does the patient have a history of head injuries (such as concussion, seizures, etc.) that resulted in personality, memory, learning speech, and/or processing issues? ☐ Yes ☐ No
If yes, are these issues still impacting the patient? ☐ Yes ☐ No

Current chronic substance use may result in the individual not being able to be evaluated.

4. Additional Information

Additional Comments (Optional):

If you would like to add additional documentation as a part of your referral (such as discharge paperwork, medical records, or release forms), please attach it along with this form.

Would you like to be followed up with on the outcome of your referral? ☐ Yes ☐ No

*****This referral is valid for 1 year from the date of submission.*****