Carol Pulley M.A.
Referral Form - PSYCHOLOGICAL EVALUATION
Adult Referral

Please fax to: 888-544-6736
If you have questions, please contact me at: 828-964-8790 or cpulley@itherapy.com.

Date: _____

Demographic Information:

Name of Client: _____ DOB: _____ Age: _____

Gender: Male _____ Female _____ Transgender M-F _____ Transgender F-M _____ Other _____

Address: Street _____ City: _____ Zip: _____

Home #: _____ Cell #: _____ Other #: _____

Email: _____

Emergency Contact Person:

Contact Person: _____ Relation to Client: _____

Home #: _____ Cell #: _____ Other #: _____

****

Referral Source:

Name: _____ Agency: _____

Phone #: _____ Fax #: _____ Email: _____

Reason for Referral (Presenting Problem, Symptoms, Needs, etc.): _____

_____

Specific Testing Requested (Please list) _____

_____

Please attach any CCAs, Intake Forms, previous evaluations & psychological testing results or other information that may be helpful.

Other Information: (Please list any additional information you would like to provide.) _____

_____

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Insurance/Funding Source:

Primary Insurance: BCBS _____ Medicaid _____ CIGNA _____ Medcost _____

(We do not accept Medicare and Tricare at this time.)

Insurance Member Number: _____

If Medicaid: Partners _____ Vaya (Smoky) _____ Carolina Access/Health Choice _____

Secondary Insurance: BCBS _____ Medicaid _____ CIGNA _____ Medcost _____

Insurance Member Number: _____

If Medicaid: Partners _____ Vaya (Smoky) _____ Carolina Access/Health Choice _____

If no insurance coverage, please indicate alternate funding source: _____

_____

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FOR OFFICE USE ONLY

Insurance Verified: Yes _____ No _____ From: _____ To: _____

Date of Initial Testing: _____

Protocols Administered: WISC V _____ WAIS IV _____ BASC P _____ BASC T _____ BASC Self _____ PAI _____

MMPI-A _____ MPACI _____ Vineland _____ Other _____ Other _____