Carol Pulley M.A.
Referral Form - PSYCHOLOGICAL EVALUATION
Child & Adolescent 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 ________________

Contact Person:

Primary Caregiver(s): ______________________________________ Relation to Client: ________________________

Address: Street _________________________________ City: _________________________ Zip: ________________

Home #: ______________________ Cell #: _______________________ Other #: ________________________

Email: ____

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Referral Source:

Name: ____ Agency: ____

Phone #: _____________________ Fax #: ______________________ Email: _________________________________

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

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Specific Testing Requested (Please list) ____

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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 ____________________

CONFIDENTIAL: Distribute to authorized individuals only.