PSYCHOLOGICAL EVALUATION REFERRAL/REQUEST FORM

To make a referral or to request an evaluation for yourself or your child, please complete all information below. Fax this form to (315) 749-7054 or email it to: lori.waterbury@kelbermancenter.org. Upon receipt, you will be placed on our waiting list and called for an appointment upon availability.

Patient Details		**Referral Source:** ☐parent ☐school ☐physician	
Patient Name:		Referral Contact Name:	
Date of Birth:		Referral Organization:	
Parent/Guardian:		Referral Phone No:	
Mailing Address:		Has referral been discussed with parent (if a minor) or patient? ☐Yes ☐No	
		Previous Diagnoses?	
Phone No:			

Insurance Information			
Primary Insurance		Policy Number:	
Medicaid Number		Willing to Self-Pay? ☐Yes ☐No	
OPWDD Eligible? ☐Yes ☐No	TABS ID #:	MSC:	

Reason for Referral:

(if only Adaptive Assessment is needed, check here ___)

Current Symptoms:

Anticipated Outcome of This Evaluation:

☐ Determination of OPWDD Eligibility

☐ Medication Management/Recommendations

☐ Educational Recommendations

☐ Identification of Learning Disability

☐ Guardianship

☐ Determination of SSI Eligibility

☐ 2nd Opinion

☐ Counseling/Treatment Recommendations

☐ Residential Treatment Planning

☐ Capacity/Consent Evaluation

☐ Other (please describe) ____

Person Completing Form:	Relationship to Patient: