Health and Human Services Agency

Donnell Ewert, M.P.H., Director

Children's Services

Dianna Wagner, MS, LMFT., Branch Director

1313 Yuba Street
Redding, CA 96001-1012
PO Box 496005
Redding, CA 96001-6005
Phone: (530) 225-5705
Fax: (530) 225-5190
CA Relay Service: (800) 735-2922

Shasta County Mental Health Children's Services
Referral for Psychological Testing

Chart Number: _____

Today's Date: _____ Name of Person Completing Referral Form: _____

PLEASE NOTE: Unless otherwise specified, the completed evaluation will be sent to the person making the referral, medical staff as appropriate and the legal guardian.

Other legal contacts (Social Worker or involved sources): _____

CHILD'S INFORMATION

Child's Name: _____ Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Lives with: ☐ Biological Family ☐ Foster Home ☐ Kinship Placement ☐ Adoptive Family ☐ Other: _____

Family Name: _____
(Provide first and last names of all caregivers)

Address: _____
(Street, Apt. #, City, State & Zip Code)

Main Phone: _____ Mobile Phone: _____ Work Phone: _____

Has this referral been discussed with the parent(s) and client?: ☐ Yes ☐ No

Is there an active IEP? ☐ Yes ☐ No If yes, please attach a copy to this referral.

CHILD PROTECTIVE SERVICES INFORMATION

Caseworker's Name: _____ e-Mail Address: _____

Phone: _____ Ext: _____ Mobile: _____Fax: _____

TESTING INFORMATION

Has the client had previous psychological testing (Psychoeducational, MIND Institute, etc. please attach)? Where and dates? Are the reports available to us?

_____

_____

Current Diagnosis: _____

How do you hope psychological testing will help you with this client's treatment?

_____

_____

_____

Are there other methods that could achieve similar results, such as alternative treatment interventions, clinical consultation, getting past records, etc.? ☐ Yes ☐ No ☐ Unsure

The following criteria must be met for approval for psychological testing: There is a need to clarify the client's diagnosis in order to further treatment and one or more of the following is true:

Multiple treatment interventions have failed; there is an unaccountable decline in the client's functioning; the client presents with a risk of non-emergency harm to self or others that is denied by the client; the client presents with unusual or high-risk behavior.

The referral behavior is present across which domains? ☐ Home ☐ School ☐ Community

What are the current symptoms promoting the request for testing?

☐ Withdrawn/Poor Social Interaction
☐ Unprovoked Agitation or Aggression
☐ Memory Impairment
☐ Sexual Behavior Issues
☐ Psychosis or Hallucinations
☐ Self-Injurious Behaviors
☐ Intellectual Functioning Concerns
☐ Bizarre Behavior
☐ Eating Disorder Symptoms
☐ Possible Developmental Delays
☐ Other: _____

Explain checked boxes above: _____
_____
_____

Add any other pertinent history you would like the Psychologist to know: _____
_____
_____

Current treatment goals: _____
_____
_____

Additional Information/Comments: _____
_____
_____

REFERRAL SOURCE INFORMATION

Relationship to child: _____ Agency of Affiliation: _____

E-Mail Address: _____ Phone: _____Ext: _____ Fax: _____

_____ _____ _____
Signature of person making the referral License Date

Completed Referrals should be faxed to:

Children's Mental Health, 1560 Market at 530-225-3866 Attn: ***Office Support – Psychological Testing***

We appreciate your taking the time to complete this referral form. Please feel free to call with any questions regarding our services or for help in completing this referral form.