Child Assessment Referral Form

REFERRING PROVIDER INFORMATION	
Provider Name:	
Phone:	
Email:	

PATIENT INFORMATION			
Patient Name:		DOB:	
Current Guardian's Name:		Phone Number:	
Guardian's Email:			

*Are there any unique circumstances we should be aware of when contacting the patient to schedule?

☐ NO ☐ YES , please describe:

*Does the patient's family have resources for participating in telehealth appointments? ☐ NO ☐ YES

PRESENTING CONCERNS/REASON FOR REFERRAL: *(What questions do you hope we can answer through testing?)*

IMPRESSIONS: *(What's your current "hunch" about what might be impacting this patient?)*

CURRENT DIAGNOSIS AND TREATMENT SUMMARY: ☐ See Attached

CURRENT AND PAST SERVICES/SUPPORTS:

☐ IEP ☐ 504 Plan ☐ Speech Therapy ☐ OT/PT ☐ Counseling ☐ WISE Program

☐ Psychiatry ☐ Behavioral Intervention Plan ☐ Foster Care ☐ CPS ☐ Probation

☐ Past Testing/Outcome Measures/Symptom Checklists Completed

☐ Other (please describe):

Please include supporting documentation.

☐ Records Attached ☐ Records Not Available ☐ Brightside to Request Records

Internal Use

Patient ID #:_____

Code:_____

203 East Third Street, Moscow, ID 83843 | (p) 208-997-4325 | (f) 833-411-1240