NYSTROM & ASSOCIATES

PSYCHOLOGICAL TESTING REFERRAL FORM

Date:_____

I. Referent Information

Referent First Name: _____ Referent Last Name: _____

Referent Organization: _____ Referent Phone: _____

Referent Email: _____ Referent Fax: _____

Referent Street Address: _____

City: _____ State: _____ Zip Code: _____

II. Patient Information

Patient First Name: _____ Patient Last Name: _____

Patient Date of Birth: _____ Patient Sex: _____ Patient Gender: _____

Patient Phone: _____ Patient Email: _____

Legal Guardian Name (if applicable): _____

Patient Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Primary language: _____ Is an interpreter needed? _____

III. Referral Details

Location: [select all that apply]

- ☐ Apple Valley, MN
- ☐ Big Lake, MN
- ☐ Bloomington, MN
- ☐ Coon Rapids, MN
- ☐ Cottage Grove, MN
- ☐ Eden Prairie, MN
- ☐ Edina, MN
- ☐ Lakeville, MN
- ☐ Maple Grove, MN
- ☐ Minnetonka, MN
- ☐ Moorhead, MN
- ☐ New Brighton, MN
- ☐ Otsego, MN
- ☐ Rochester, MN
- ☐ St. Cloud, MN
- ☐ Woodbury, MN

Reason for Referral: [select all that apply]

- ☐ ADD/ADHD Testing
- ☐ Autism Testing
- ☐ Bariatric Evaluation
- ☐ Disability Evaluation (does not include forms)

- ☐ Disability Evaluation with Forms (forms must be attached)
- ☐ Emotional/Behavioral/Personality Concerns
- ☐ IQ/Intellectual Disability/Adaptive Functioning
- ☐ Learning Concerns
- ☐ Neuropsychological Testing
  - Significant cognitive learning/development/memory concerns
- ☐ Other: _____

Is the Referral Court Ordered ☐ Yes ☐ No

Has the patient been previously diagnosed with Autism? ☐ Yes ☐ No

Does the patient have a history of head injuries (such as concussion, seizures, etc.) that resulted in personality, memory, learning speech, and/or processing issues? ☐ Yes ☐ No
If yes, are these issues still impacting the patient? ☐ Yes ☐ No

Current chronic substance use may result in the individual not being able to be evaluated.

*****This referral is valid for 6 months from the date of submission.*****