

# REFERRAL

Bradley A. Schuyler, Ph.D.

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Kristin Tristao, Ph.D.

Date:	Referred by:
Phone:	Contact Person:

Type of Service:  Individual/Marital/Family Therapy  Psychological Evaluation  
 ADHD / LD Evaluation  Medical/Legal Evaluation  
 Neuropsychological Evaluation  Cognitive Skills Training

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

Zip

Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_ Email: \_\_\_\_\_

**If patient is a minor:**

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

**Primary Insurance:**

Company: \_\_\_\_\_

Phone: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Subscribers ID: \_\_\_\_\_ Group #: \_\_\_\_\_

SS#: \_\_\_\_\_

Authorization Information: \_\_\_\_\_

**Secondary Insurance:**

Company: \_\_\_\_\_

Phone: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Subscribers ID: \_\_\_\_\_ Group #: \_\_\_\_\_

SS#: \_\_\_\_\_

Authorization Information: \_\_\_\_\_

**Worker's Compensation / Medical Legal / Independent Medical Examination**

DOI: \_\_\_\_\_ Case #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Employer: \_\_\_\_\_ Name of Adjuster: \_\_\_\_\_

Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Authorization Information: \_\_\_\_\_

Patient's Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Defense Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**REASON FOR REFERRAL:**

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