ADHD PSYCHOLOGICAL TESTING REFERRAL FORM

Send completed form to:

Email: patients@matthewbergermd.com | Fax: (570) 207-0615

Offices of Psychiatry & Counseling Services
Matthew A. Berger, MD, PC

REFERRAL SOURCE INFORMATION

Referring provider: _____ NPI #: _____

Practice/Organization: _____

Address: _____

Email: _____ Provider Phone #: _____ Fax #: _____

PATIENT INFORMATION

Patient name: _____ Preferred name: _____

Date of birth: _____ Gender: _____

Current diagnosis code(s): _____

Address: _____ Phone #: _____

QUESTIONS TO BE ANSWERED WITH TESTING

1. Please list specific diagnostic or treatment-related questions you would like to address:

2. How would the results of testing affect the treatment plan? Be specific.

3. Is this court ordered? ☐ Yes ☐ No

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PREVIOUS TESTING

4. Has this member had previous psychological/neuropsychological testing?

☐ Yes ☐ No ☐ Unsure

If YES, explain where/when testing occurred and the results (attach a copy if available):

CURRENT REPORTED SYMPTOMS / PRESENTING CONCERNS

Inattention concerns - check all that apply:

☐ Misses details / careless mistakes

☐ Difficulty sustaining attention

☐ Does not seem to listen when spoken to

☐ Starts tasks but does not follow through

☐ Difficulty organizing tasks

☐ Poor time management

☐ Avoids/dislikes tasks that are not interesting

☐ Loses items frequently

☐ Easily distracted

☐ Forgetful with everyday tasks

Hyperactivity / Impulsivity concerns - check all that apply:

☐ Fidgets/taps hands or feet / squirms

☐ Unable to stay seated

☐ Runs/climbs at inappropriate times

☐ Unable to stay quiet during activities

☐ Always "on the go" / feels restless

☐ Excessive talking

☐ Interrupts conversations / blurts answers

☐ Unable to wait for turn

☐ Interrupts / intrudes on others

Symptoms present before age 12: ☐ Yes ☐ No

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SYMPTOM SETTINGS & FUNCTIONAL IMPACT

Locations where symptoms have been a concern - check all that apply:

- ☐ Home
- ☐ School
- ☐ Work
- ☐ With friends/relatives
- ☐ During activities
- ☐ Other _____

Areas of life concerns have affected - check all that apply:

- ☐ Home
- ☐ Work
- ☐ School
- ☐ Other _____

SUBSTANCE USE

Has the member used any substances in the last 30 days?

- ☐ No
- ☐ Yes - describe: _____

Additional details:

REFERRAL ATTACHMENTS

Please include the following with your referral, if available:

- ☐ Most recent progress note
- ☐ Medication list

IMPORTANT

All information must be thoroughly answered.

If anything is missing, we will be unable to process this referral.