ADHD PEDIATRIC PSYCHOLOGICAL TESTING REFERRAL FORM

AGES 6-17

Email: patients@matthewbergermd.com | Fax: (570) 558-6838

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

REFERRAL SOURCE INFORMATION

Referring provider: _____ NPI #: _____

Practice/Organization: _____

Address: _____

Email: _____ Phone #: _____ Fax #: _____

REASON FOR REFERRAL

☐ Does patient meet DSM-5 criteria for ADD/ADHD - Attention Difficulties

☐ Does patient meet DSM-5 criteria for Autism Spectrum disorder

PATIENT INFORMATION

Patient name: _____ Preferred name: _____

Age: _____ Date of birth: _____ Gender: _____

Patient address: _____

Current diagnosis code(s): _____ Patient phone #: _____

PARENT / GUARDIAN INFORMATION

Parent/Guardian name: _____ Phone #: _____

Relationship to patient: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Other

Other relationship: _____ Email: _____

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INSURANCE INFORMATION

Primary insurance: _____ Secondary: _____

Member ID: _____

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. 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):

4. Has member had a school-based psychological evaluation? If YES, specify date:

CURRENT REPORTED SYMPTOMS / PRESENTING CONCERNS FOR ADD/ADHD

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
☐ Difficulty with tasks that are not interesting
☐ Loses items frequently
☐ Easily distracted
☐ Forgetful with everyday tasks

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HYPERACTIVITY / IMPULSIVITY CONCERNS

- ☐ Fidgets/taps hands or feet / squirms in seat
- ☐ Unable to stay seated
- ☐ Runs/climbs at inappropriate times
- ☐ Unable to stay quiet during activities
- ☐ Always "on the go" or feels restless
- ☐ Excessive talking
- ☐ Interrupts conversations / blurts out answers
- ☐ Unable to wait for turn
- ☐ Interrupts / intrudes on others

SYMPTOM HISTORY & FUNCTIONAL IMPACT

Symptoms present before age 12: ☐ Yes ☐ No

Locations where symptoms have been a concern:

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

Areas of life concerns have affected:

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

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.