AUTISM PEDIATRIC PSYCHOLOGICAL TESTING REFERRAL FORM

AGES 6-17

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: _____

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: _____

QUESTIONS TO BE ANSWERED WITH TESTING

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

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QUESTIONS TO BE ANSWERED WITH TESTING (CONTINUED)

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 the member had a school-based psychological evaluation? If YES, specify date:

5. Is this court ordered? ☐ Yes ☐ No

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

☐ Yes - describe: ☐ No

CURRENT REPORTED SYMPTOMS / PRESENTING CONCERNS FOR ASD

Social Communication / Interaction concerns - check all that apply:

☐ Difficulty with reciprocal conversation
☐ Limited or atypical eye contact
☐ Difficulty interpreting social cues
☐ Challenges with developing/maintaining peer relationships
☐ Reduced social reciprocity
☐ Literal or concrete communication style
☐ Atypical emotional expression
☐ Social anxiety related to social confusion
☐ History of masking/camouflaging behaviors
☐ Other:

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RESTRICTED / REPETITIVE BEHAVIORS / SENSORY FEATURES

- ☐ Intense or highly focused interests
- ☐ Rigid routines or distress with change
- ☐ Repetitive movements or behaviors
- ☐ Repetitive speech/scripts
- ☐ Sensory sensitivities
- ☐ Sensory seeking behaviors
- ☐ Difficulty with transitions
- ☐ Black and white thinking/cognitive rigidity
- ☐ Other: _____

FUNCTIONAL IMPACT

Symptoms/traits are impacting functioning in the following areas:

- ☐ School/academic functioning
- ☐ Occupational functioning
- ☐ Family functioning
- ☐ Peer/social relationships
- ☐ Emotional regulation
- ☐ Independent living/adaptive skills
- ☐ Treatment participation/diagnostic clarification
- ☐ Other: _____

OTHER RELEVANT HISTORY

- ☐ Concerns present since childhood/developmental period
- ☐ Prior mental health diagnoses may not fully explain presentation
- ☐ History of social difficulties across settings
- ☐ Family history of autism/neurodevelopmental differences
- ☐ Previous autism evaluation inconclusive/not completed

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.