Dr. Georgien Dudzek
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Janesville, WI 53546
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CrossRoads

PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING REFERRAL

DATE _____

CLIENT NAME_____ DOB: _____ Age: _____

ADDRESS_____

Street City State Zip Code

PHONE # _____ PARENTS NAME, IF MINOR _____

INSURANCE SOURCE _____

REFERRING PROVIDER_____ PHONE _____

TYPE OF REFERRAL _____DAY TX _____ONGOING CLIENT _____OTHER

TYPE OF TESTING REQUESTED:

_____PSYCHOLOGICAL/ MENTAL HEALTH _____NEUROPSYCHOLOGICAL/ COGNITIVE

REASONS FOR TESTING/SPECIFIC REFERRAL QUESTIONS TO BE ANSWERED_____

_____

_____

_____

_____

RELEVANT HISTORY/PRESENTING SYMPTOMS: _____

_____

_____

_____

_____

CURRENT DX _____

CURRENT MEDICATION_____

_____

PRIOR PSYCHOLOGICAL TESTING	Yes	No
PRIOR NEUROPSYCHOLOGICAL TESTING	Yes	No
IS THIS A COURT ORDERED EVAL—IF YES, PLEASE *ATTACH COURT ORDER AND SOURCE FOR PAYMENT	Yes	No
IF MINOR, DOES PARENT HAVE LEGAL GUARDIANSHIP	Yes	No

ADDITIONAL INFORMATION

*****Please attach any relevant document including appropriate release of information, IEP, prior evaluations and additional information regarding current referral question.*****

_____ **INTAKE APPROVED**

_____ **INTAKE DENIED**

REASON FOR DENIAL_____

** Please return to Dr. Dudzek when scheduled and provide a copy to referral source**

N:Georgien/psychological/neuropsychologicaltestingreferral