Riverside University Health System – Behavioral Health
REFERRAL FOR PSYCHOLOGICAL TESTING

Unless otherwise specified as part of this order, this request shall be effective until 180 days from this order unless otherwise terminated or modified by this court.

☐ MEDI-CAL (CARES) ☐ DPSS (ACT) ☐ GROUP HOME (CARES)

* See Page 3 for directions for where to send requests. Please type or print legibly and answer all questions thoroughly. If more space is needed for any questions, please attach additional pages.

Date of Request: _____

Consumer's Name: _____

Consumer's SSN#: _____ Consumer's Date of Birth: _____

Current Living Situation: ☐ Group Home ☐ Bio Parent(s) ☐ Legal Guardianship ☐ Adopted Parent(s) ☐ Foster Home
☐ FFA (Private Foster Home) ☐ Relative Placement (Minors) ☐ Shelter Home ☐ Board & Care ☐ IMD ☐ SNF
☐ Independent Living ☐ Other: _____

Name of Residential Facility: _____

Address of Residential Facility: _____

Phone # of Residential Facility: _____ Date of Placement: _____

MHP Provider # (if applicable): _____

Referent Phone #: _____ Fax #: _____

Referent's Agency Name (if applicable): _____

Nature and history of presenting problems related to Medical Necessity Criteria:

Diagnosis:

ICD 10 Code:

Axis I: _____ _____

Secondary _____ _____

Axis II: _____ _____

Axis III: _____ _____

Axis IV: _____
(Specific Psychosocial Stressors)

Axis V: _____ / _____
Current Highest in Past Year

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CONSUMER NAME: _____ SS#: _____

Nature and progress of treatment to date (including # of sessions with consumer):

History of institutional placements (Psychiatric Hospitals, Group Homes, Shelter Homes, IMD):

Psychological testing in last two years (Date, Types of Tests, Referral Question):
** Copies of Psychological Tests are Requested if Available

Specific Questions to be Answered by Psychological Testing:

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CONSUMER NAME: _____ SS#: _____

Other methods that have been tried to answer these questions and why haven't they sufficed:

How will result of testing specifically be used to impact treatment? Give examples:

Name of Psychologist Recommended to Perform Testing (Optional): _____

Referent's Signature & Title: _____ License #: _____

Referent's Printed Name & Title: _____

Where To Send Form:

For Medi-Cal and Group Home Consumers – Fax form to Community Access, Referral, Evaluation & Support (CARES) at (951) 358-5352 or Mail to CARES * P O Box 7549 * Riverside, CA 92513

For DPSS Consumers of ACT – Fax completed form to (951 687-5819) or
Mail to ACT * P O Box 7549 * Riverside, CA 92513