Riverside County Mental Health Plan

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 ☐ Shelter Home ☐ Foster Home ☐ Bio Parents ☐ Relative Placement ☐ Board & Care ☐ Independent Living Arrangement ☐ MD/SNF ☐ 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:

Axis I: ____________ ____________

Secondary ____________ ____________

Axis II: ____________ ____________

Axis III: ____________ ____________

Axis IV: ____________
(Specific Psychosocial Stressors)

Axis V: ____________ / ____________
Current / Highest in Past Year

Confidential patient information. See California Welfare and Institutions Code Section 5328

Riverside County Mental Health Plan

REFERRAL FOR PSYCHOLOGICAL TESTING

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:

Riverside County Mental Health Plan

REFERRAL FOR PSYCHOLOGICAL TESTING

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

Confidential patient information. See California Welfare and Institutions Code Section 5328