Accident Injury & Family Therapy, Inc.

(800) 399-9773
Fax: (714) 639-0072

Request for Evaluation by Psychological and/or Psychiatric Specialist

Patient: _____ Date of Injury: _____ / _____ / _____

DOB: _____ / _____ / _____ Claim #: _____

SSN: _____ Patient's Phone #: _____

Patient's Address: _____

Insurance Carrier: _____

Address: _____

_____

I am referring the above referenced patient for an evaluation. I am the primary care provider for this patient. I look forward to receiving an evaluation report and recommendations for any needed treatment, which will serve as an adjunctive part of my primary treatment program (unless otherwise indicated).

This patient is being referred because:

- ☐ He/She has been in treatment for an extended period of time, has shown no significant improvement, and is at risk for developing psychological problems.
- ☐ He/She is currently manifesting signs of psychological distress. These symptoms include:

__ Anxiety	__ Anger
__ Sadness	__ Suicidal Thinking
__ Difficulty Sleeping	__ Impaired Memory/Concentration
__ Relationship Problems	__ Other/Additional Problems

This is based upon the following:

- ☐ Clinical observation in my direct work with this patient
- ☐ Patient Self-report of symptoms to me
- ☐ Patient Self-report of symptoms on one or more psychological screening tests
- ☐ Collateral report of symptoms
- ☐ See Attached

I am also including the following information with this referral. Please feel free to contact our offices if you need any additional information.

- ☐ PR-2
- ☐ Proof of Service by Mail (for PR-2)

Doctor Name: _____

Doctor Signature: _____ Date: _____ / _____ / _____

Revised 04/01/07