

**Psychological Services  
Request for Assessment Form**

|                      |            |
|----------------------|------------|
| Referred By:         | Contact #: |
| Organization/Agency: |            |
| Title:               | Email:     |

**Client Information**

|                          |                   |                           |
|--------------------------|-------------------|---------------------------|
| Client Name:             | DOB:              | Age:                      |
| Preferred Name:          | Legal Gender: M F | Identifies As:            |
| Street Address:          |                   |                           |
| City:                    | State:            | Zip:                      |
| Home #:                  | Cell #:           | Work #:                   |
| Email:                   |                   |                           |
| Is Client Verbal: Yes No | Language:         | Translator Needed: Yes No |

**Parent Information**

|                                     |        |      |
|-------------------------------------|--------|------|
| Parent/Guardian Name:               |        |      |
| Address: (if different than client) |        |      |
| City:                               | State: | Zip: |
| Phone #:                            | Email: |      |

**Insurance Information**

|                               |                   |
|-------------------------------|-------------------|
| Insurance Provider:           | Member ID:        |
| Person who Carries Insurance: | Group #:          |
| Insurance Carrier DOB:        | Member Service #: |

**Legal Contacts**

|                |          |
|----------------|----------|
| Probation:     | Phone #: |
| Attorney:      | Phone #: |
| Social Worker: | Phone #: |

**Current Treatment Providers Name, Agency, and Phone #:**

|                  |          |
|------------------|----------|
| Chemical Health: | Phone #: |
| Mental Health:   | Phone #: |
|                  |          |

Have you Discussed the Need for this Evaluation with Client or Clients Parent/Guardian:      Yes      No

**Evaluation Information**

|   |   |                       |
|---|---|-----------------------|
| <b>Psychological Evaluation Type Needed (check all that are needed)</b> |   | Return to Court Date: |
|   | Diagnostic Clarification/Implications for Treatment     |                       |
|   | Developmental Disabilities (Cognitive and Functional)   | Evaluation Needed By: |
|   | Neurodevelopmental Evaluation                           |                       |
|   | FASD (Fetal Alcohol Spectrum Disorder)                  |                       |
|   | ASD (Autism Spectrum Disorder)                          |                       |
|   | Civil Commitment  | Send Report To:       |
|   | Child Protection: CHIPS TPR Parent Capacity             |                       |
|   | Guardianship/Conservatorship                            |                       |
|   | PSI-Correctional Psychological Evaluation               |                       |
|   | Psychosexual Evaluation                                 | Other:                |
|   | Certification to Be Tried as an Adult                   |                       |
|   | Rule 20.01, 20.02 Juvenile Competence to be Tried, NGRI |                       |
|   | Forensic Risk Evaluation                                |                       |

Has the Client had any previous Evaluations (Chemical or Mental):

If Yes, When and Where:

Does Client have an IEP or 504 Plan at School:

What are the Symptoms and Concerns for needing/wanting this Evaluation:

As a result of this Evaluation, what would you like to Learn:

Court Ordered Evaluation Requests need to be submitted along with the Court Order, Criminal Complaints, Police Reports, PSI, and Statement of Probable Cause