| **Testing Referral Questionnaire*****Please complete this form by typing your responses in the available fields*** ***(we cannot process handwritten forms).*** ***Email your completed form as an attachment to*** ***testing@sollarsassociates.com******.*** ***We will be in touch within 48 business hours. Thank you.***

| **Today’s Date** |  |
| --- | --- |
| **Client Name** |  |
| **Caller / Guardian Name / Relationship** |  |
| **Client / OR Guardian Phone Number**  |  |
| **Client / Guardian EMAIL ADDRESS** |  |
| **Client Age** |  |
| **Insurance Provider** |  |
| **Any Documentation Associated with Request? (Ex. Court Order)** |  |

| **Type of** **Evaluation****(REQUIRED)** | **Reason for Evaluation****(REQUIRED)** | **Details**Ex. My daughter was suspended for fighting. Ex. I am having trouble remembering daily tasks. |
| --- | --- | --- |
|  | ADD / ADHD |  | Behavioral Concerns |  |
|  | Autism |  | Academic Concern |  |
|  | Learning Disabilities |  | Cognitive/Memory Concern |  |
|  | Disability Evaluation |  | Other |  |
|  | Other |  |  |  |
| **Requested By****(REQUIRED)** |  | **Do you have a referral? (Y/N)** | **Details**Ex. Math Teacher reports my son is having trouble focusing in class. |
|  | Client / Client Guardian |  |  |  |
|  | School |  |  |  |
|  | Physician |  |  |  |
|  | Employer |  |  |  |
|  | Court Ordered |  |  |  |
|  | Other |  |  |  |

 |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |