| **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***](mailto:testing@sollarsassociates.com)***.***  ***We will be in touch within 48 business hours. Thank you.***   | **Today’s Date** |  | | --- | --- | | **Client Full LEGAL Name** |  | | **Client PREFERRED Name** |  | | **Caller / Guardian Name / Relationship** |  | | **Client / OR Guardian Phone Number** |  | | **Client / Guardian EMAIL ADDRESS** |  | | **OK to LM / Text** |  | | **Best Time to Call**  *Please be as specific as possible and provide AM and PM times whenever possible. The faster we can reach you, the quicker we can begin the Testing Process. Thank you.* |  | | **Client Date of Birth** |  | | **Client Age** |  | | **Client Gender / Preferred Pronoun** |  | | **Insurance Provider**  *Molina Medicaid will NOT cover Testing Services. Clients must pay CASH for services.* |  | | **Client City of Residence** |  | | **Traveling for Testing Services**  *Due to the increase in demand for testing services, the approximate travel time is 20-30 minutes. However, if you are able to travel further, more scheduling options may be available at additional locations. Please let us know how far you are comfortable with traveling for your testing session.* |  | | **Are you currently receiving THERAPY SERVICES through Sollars and Associates?** |  | | **If Client is a MINOR, is there a CUSTODY AGREEMENT in place?**  *Please provide details including other parent’s name and contact information. We will request a copy of the Custody Agreement before Testing Services are rendered.* |  | | **Any Documentation Associated with Request? (Ex. Court Order)**  *Court Ordered Testing Services are not covered*  *by Insurance. We can offer a cash rate.* |  |  | **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 |  |  |  | | ***Disclaimer: I****f you are taking medication for any of the symptoms for which you’re being tested, this may impact the results of your evaluation. Please discuss this with your prescriber prior to testing.* | | | | | |
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