SAPIA PSYCHOLOGICAL ASSOCIATES

4320 Southport-Supply Rd., Suite 200, Southport, NC 28461
Phone 910-457-0800; Fax: 910-457-1072

Child Psychological Assessment Referral

Date of Referral: _____

Client Name:_____DOB:_____

Address: _____ Phone:_____

School/Grade:_____ Phone:_____

Previous Psychological Assessments? Yes___ No____ Type_____
If yes, do we have access to reports? (Give Provider Contact Information to request records_____

Previous Mental Health Treatment? Yes____ No_____ Type: Therapy_____ Medication Management_____

If Current Treatment
Diagnosis:_____
Medications:_____
_____

Exceptional Children's Program Classification if any:_____

Any Rating Scales completed at school or another provider (list):
_____
PresentingProblems/Concerns:_____
_____
_____
_____
Referral Questions (what questions would you like answered): MUST BE COMPLETED
1._____
2._____
3._____

Health Insurance Coverage_____
Policy Number_____

Contact Information to schedule Appointment:
Name:_____ Phone:_____

Relationship to client:_____