

# PCP Psychological Evaluation Request



Referring Provider Name: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

NPI: \_\_\_\_\_

Office Address: \_\_\_\_\_

Referred Member Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

DOB: \_\_\_\_\_ CenCal ID: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason for Consultation (Please describe the reason member is being referred and provide a brief clinical background):

## Provided Documents (Highly Recommended)

- Member's evaluation history
- Health and Physical
- Recent Progress Notes and Treatment Plans (may include those provided by a mental healthy provider)
- School and Regional Center Records (IEP, IFSP, Service Plans, and Psychological Testing)