BREE RILEY, PSY.D.
LICENSED PSYCHOLOGIST

Riley Counseling, LLC
790 Northern Blvd
South Abington, PA 18412

Psychological Assessment Referral

Please EMAIL this referral form, a copy of the patient's insurance card, AND an ROI to: drbreeriley@gmail.com
Once reviewed, Dr. Riley will contact the patient for scheduling.

Client Information
Patient Name:______________________________ Date of Referral:____________
DOB:______________ Grade/School:______________
Age:_________ (If Applicable)

Contact Person for Scheduling
Name: _____________________________________
Phone: _____________________________________ Okay to leave a message: Yes___ No___
Email: _____________________________________ *Patient Email Required

Referral Source
Referring Professional(s): ____
Practice Name: ____
Relationship to Patient: ____________________________________
Phone: _______________________________
Address: ____

Insurance Information
*Please attach insurance card or check off self-pay
Pre-auth needed? Yes: ____ No: ____ If so, has this been completed? Yes: ____ No: ____
OR
Self-Pay: ______

Clinical Reasons for Requesting Evaluation
The testing must be medically necessary for insurance reimbursement. Medical necessity is defined as: a service which in the opinion of the primary service provider is reasonably needed to prevent the worsening of a condition, to establish a diagnosis and/or to assist the individual in achieving maximum functional capacity.
PLEASE CLEARLY DEFINE THE MEDICALLY NECESSARY REASONS FOR THIS INDIVIDUAL TO RECEIVE TESTING. (Attach additional explanation/documents if necessary)

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Check All that Apply

____ Personality and/or Mood Assessment
____ IEP Assessment
____ ADHD and/or Autism Spectrum Disorder Assessment
____ Cognitive, IDD, IQ/Intelligence, Learning Disability
____ Trauma, Dissociative Disorders, and/or DID Assessment
____ Other: ____

Current Services

____ Therapy/Counseling ____ Medical Care
____ Psychiatric Care ____ Special Education and/or IEP
____ Other: ________________________________
Explain: ____
____

Current Medications

____
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Current Diagnoses

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____
____

If PCP

Recent labwork: ___ Yes ___ No Date: __________________
Relevant Medical Issues:
____
____
____

Other Comments

____
____
____
____
____

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