WILLOW MEDICAL
& wellness

PSYCHOLOGICAL TESTING REFERRAL FORM

Stephanie Richardson, Psy.D, LP, LPC

Patient Full Name	Date of Birth	Age Gender	Scheduling Phone Number
Gaurdian if Applicable	Relation to Patient		Scheduling Email
Referring Provider Name	NPI		Date
Clinic Name	Phone		Fax

BRIEFLY EXPLAIN PURPOSE FOR REFERRAL :

Current and/or Prior Treatments:

☐ Psychotherapy ☐ Medications ☐ TMS ☐ ECT ☐ Other:

PRESENTING CONCERNS:

☐ Anxiety	☐ Depressed mood	☐ Inattention	☐ Self-harm behaviors
☐ Excessive worry	☐ Mood dysregulation	☐ Poor Focus	☐ Obsessive/Compulsive Symptoms
☐ Irritability	☐ Communication skills	☐ Distractibility	☐ Substance Use
☐ Insomnia	☐ Interpersonal issues	☐ Hyperactivity	☐ Psychosis
☐ Fatigue	☐ Memory/Forgetfulness	☐ Impulsivity	☐ Suboptimal response to treatments

REASON FOR REFERRAL: (*Please check all that apply)*

☐ Provide Diagnostic Clarification ☐ Assist with Treatment Planning ☐ Assess Cognitive Functioning

ICD-10 DIAGNOSES Codes For Prior Authorization:

Does the patient need any accomodations? ☐ **No** ☐ **Yes:** *(details)*

PATIENT INSURANCE INFORMATION: *We **do not** accept* **Medicaid/Medicare/Workman's Compensation**

Primary Insurance Carrier	Subscribers Name	
Policy Number/Member ID	Group Number	
Patients Relationship to Subscriber	Subscriber Date of Birth	Last 4 of Subscriber SS#
Secondary Insurance Carrier	Subscribers Name	
Policy Number/Member ID	Group Number	
Patient's relationship to subscriber	Subscriber's Date of Birth	Last 4 of Subscriber SS#

UPLOAD form via website or FAX to 907-222-0754

Please include relevant medical records: intake evaluations, current diagnoses, most recent appointment notes, current medications, a summary of active medical problems and a Release of Information.

We appreciate your referrals!

920 E 72nd Avenue Anchorage, Alaska 99518 Phone: 907.222.0753 Fax: 907.222.0754
willowmedicalwellness.com

RELEASE OF INFORMATION

WILLOW MEDICAL
& wellness

CLIENTS NAME:_____Date of Birth:_____

Today's Date: _____

Requesting Entity:	Releasing Entity:_____
Willow Medical & Wellness 920 East 72nd Avenue Anchorage AK 99518 Tel: 907.222.0753 Fax: 907.222.0754	_____ Street Address _____ City / State / Zip _____/_____ Fax Phone

_____(initial) I authorize this release to be reciprocal between the two parties.

INFORMATION AUTHORIZED FOR RELEASE

- ☐ Psychological Evaluations/Reports
- ☐ Psychiatric Evaluations/Reports
- ☐ Physical / Medical Records / Med. List
- ☐ Lab Results
- ☐ Radiology Reports (CT/MRI)
- ☐ Emergency Reports
- ☐ Psychotherapy Notes
- ☐ Social History
- ☐ Vocational/ Work Information
- ☐ Discharge Summary (ies)
- ☐ Verbal Information
- ☐ Any documents which may include information regarding **HIV status**.
- ☐ Any documents which may include information regarding **chemical dependency.**
- ☐ Other _____

I hereby authorize the above information to be released to the party I have indication for the purpose of:
☐ continuity of care ☐ other:_____
I retain the right to revoke this authorization in writing prior to the expiration date below.

Treatment may not be conditioned on obtaining the authorization if that is prohibited by the HIPPA Privacy Rule. The information disclosed pursuant to this authorization may be subject to re-disclosure by the designated recipient, and subsequently no longer protected by the HIPAA Privacy Rule.

*I understand that authorizing the disclosure of the above information is **voluntary** and I need not sign this form to ensure treatment.*

_____ _____
Signature of Client or Client's Designee *Designee's Relationship to Client*

_____ _____ *TO* _____
Witness *Date Authorized* *Date Authorization ends*