



MindSights Psychological Testing and Assessment Referral Information

Client/Patient Name: _____ Date of Birth: _____
Primary Contact Information: Phone: _____ Check if this # can receive texts:
Email: _____
Address: _____
Patient's Primary Language? _____ Parent/Caregiver's? _____

Parent/Caregiver's Name (if patient is a minor): _____
Legal Guardian (if different from above): _____
Guardian's Contact Information: Phone: _____ Email: _____

Referring Provider: _____ Clinic/Agency: _____
Provider's Contact Information: Phone: _____ Fax: _____
Email: _____
Address: _____

Payer Information: Commercial/Employer-sponsored health plan (using out-of-network benefits)
Please check all Oregon Health Plan (OHP ID: _____)
That apply. Self-pay/private pay
 Other: (please specify) _____

Reason for Referral:

Additional Notes:

Thank you for your referral. Please attach any relevant provider notes/reports, and submit with this form via encrypted email to office@mindsightspx.com, or fax it to 503-764-9646.