MindSights Psychological Testing and Assessment Referral Information

Client/Patient Name: _____ Date of Birth: _____

Sex Assigned at Birth (for insurance purposes): ☐ Male ☐ Female

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: _____

Preferred MindSights Location: ☐ Portland ☐ Beaverton ☐ Bend

Referring Provider: _____ Date of Referral: _____

Clinic/Agency: _____

Provider's Contact Information: Phone: _____ Fax: _____

Email: _____

Address: _____

_____

Payer Information: Please check all That apply.

- ☐ Commercial/Employer-sponsored health plan (using out-of-network benefits)
- ☐ Oregon Health Plan (OHP ID: _____)
- ☐ 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@mindsightspdx.com, or fax it to 503-764-9646.