Center for Behavioral Health
University of Missouri – St. Louis

PSYCHOLOGICAL EVALUATION REFERRAL FORM

Child's Name: _____Date of referral: _____

Address: _____
(Street)

_____
(City, State Zip Code)

Date of Birth:_____ Sex:_____

Racial/Ethnic Background (Optional for Missouri Human Rights Compliance Report):
(please circle):

Asian African-American Caucasian

Native American Hispanic Other:_____

Legal Guardian(s):_____Relationship:_____

Guardian's Phone: (Home) _____ (Work)_____(Cell)_____

Other important contacts:_____ Relationship:_____

Phone: (Home) _____ (Work)_____(Cell)_____

School District:_____ School:_____

Teacher's Name_____Grade_____

Referring Staff Member: _____Phone:_____

Briefly describe your reasons for requesting services for this student:_____

_____

_____

Please list any medications the child is taking, if any:_____

Upon completion, please fax this form to CBH Intake at 314-516-5347