

### 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: (Cell) \_\_\_\_\_ Guardian aware of referral: yes / no

Guardian's Email: \_\_\_\_\_

Other important contacts: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (Cell) \_\_\_\_\_

School District: \_\_\_\_\_ School: \_\_\_\_\_

Grade \_\_\_\_\_

Referring Staff Member: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Staff Member's relationship to child: \_\_\_\_\_

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 314-516-4863**