

HUFFMAN PSYCHOLOGY, PLLC

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Clinical Psychology and Neuropsychology Services

REFERRAL FORM

To make a referral to Huffman Psychology, please complete and fax to 517-337-9545. We will call the patient directly to explain services and schedule an appointment.

Please check the service you are referring the patient for:

Neuropsychological Evaluation **Child and Adolescent Psychotherapy**

Demographic Information (Please complete or fax copy of patient information):

Patient Name _____ DOB _____ Age _____
Sex: Male Female Patient SSN _____
Parent/Guardian Name (if patient under 18) _____
Street Address _____
City _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Preferred number for contact _____
Can we leave message at this number? No Yes

Referring Office Information (Please complete or fax with cover sheet):

Referral From _____ Dr.'s Office _____
Phone _____ Fax _____

Insurance Information (Please complete or fax copy of insurance cards):

Name of Insurance Company _____
Policy or ID Number _____ Group Number _____
Policy Holder's Name _____ Policy Holder's DOB _____
Relationship to Patient _____
Policy Holder's Employer _____

Referral Question Information (Please complete or send copy of Dr.'s notes):

Current concerns (check all that apply):

<input type="checkbox"/> ADHD	<input type="checkbox"/> Depression/Mood	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Learning Disorder	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Dementia
<input type="checkbox"/> PDD-NOS/ASD	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Stroke
<input type="checkbox"/> Autism	<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Competency
<input type="checkbox"/> Asperger's Disorder	<input type="checkbox"/> Toileting Concerns	<input type="checkbox"/> Sleep Concerns
<input type="checkbox"/> Trauma	<input type="checkbox"/> Noncompliance/Defiance	<input type="checkbox"/> Other (specify) _____

Please include information regarding relevant medical history, current diagnosis and current medications (Please note below or fax on a separate sheet):

