Providing Evidence-Based Evaluation, Treatment, and Consultation

PATIENT REFERRAL FORM

Referring Professional:____________________________________
Person to contact regarding referral:__________________________
Phone:____

Patient Name:_____________________________Age:__________
Parent/Guardian:____
Phone:____

Referral to:

_____Paula Morse, L.P.C.
_____Laura Horton, Ph.D.
_____Jill Lorge, M.S., CCC-SLP
_____Jason LaGory, Ph.D.
_____Adam H. Benton, Ph.D.
_____Mary M. Ekdahl, Ph.D.
_____First available (for psychological evaluation or psychotherapy)

Service(s) Requested:

_____Evaluation
_____Treatment

Presenting Concerns (include “rule out” diagnoses):

_____Behavior Problems
_____Depression
_____Learning Problems
_____Trauma
_____Sexual Behavior Problems
_____Social Skills
_____Motor Skills
_____Speech and Language
_____Other:

_____Attention Deficits
_____Anxiety
_____Autism Spectrum Disorder
_____Abuse/Neglect
_____Parent-child Problems
_____Grief
_____Sensory Processing

Other requests/information: _____________________________________
____

Thank you for your referral!

4004 McCain Blvd., Suite 203, North Little Rock, AR 72116 Phone: 501-812-4268 Fax: 501-812-4286