SAINT JOSEPH MERCY HEALTH SYSTEM
A Member of Mercy Health Services

Saint Joseph Mercy Outpatient Behavioral Services

Request for Psychological Testing

Referral Date:______________ Requested by:____

Client Name:____________________________________ Age:___ DOB: __________Sex:____

Parent/Guardian Name (if applicable):____

Client Phone Number(s): Home:_____________________ Cell/Work:_____________________

Insurance Provider: ______________________

Is the client currently being seen here at our clinic? Yes ☐ No ☐ Not Sure ☐

If yes, what are the names of their therapist and psychiatrist?

Therapist: _____________________________

Psychiatrist: ___________________________

Presenting Problems:

Significant History:

Specific Referral Questions:

Requesting/Supervising Physician Signature (required):

Please note: Testing will not be performed without a physician's signature.

Please retain one copy for the client's chart and fax or mail this form to:
Saint Joseph Mercy- Outpatient Behavioral Services
2006 Hogback Rd., Ste. 1
Ann Arbor, MI 48105
Attn: Psychological Testing Services

Fax: (734) 786-4915 (If faxing, please follow up with a phone call to ensure that the referral was received).

If you have any questions, please call us at (734) 786-8003 or (734) 786-2300.

For office use only
Date Assigned: ______________________
Examiner: __________________________ Type of Testing: __________________________________
Supervising Clinician's Signature: _________________________