ARBOR HILLS
PSYCHOLOGICAL SERVICES

Psychological Testing Referral Form — Arbor Hills Psychological Services

Client name:	
Date of birth:	
Name of guardian:	
Contact phone:	
Email:	
Insurance provider:	
Subscriber/ID number:	
Clear referral questions: What specifically do you want to know?	
Presenting problems and symptoms: List specific, observable behaviors and symptoms	

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Functional impact: Detail how symptoms affect work, school, relationships			
Relevant history: Include previous psychiatric diagnoses, treatments, medications, family history, and trauma history			
Referring Provider:			
Phone:		**Fax:**	

Important information and next steps

- Incomplete referrals will delay scheduling.
- Kindy instruct patients to call our office to request scheduling.
- Fax referrals to 517-750-3673 or email to alex@arborhillsps.com
- If your practice prefers to use a different format from this form, please ensure this information is included.

Scheduling & waiting times

- Wait time varies by insurance plan, nature of referral, and clinician availability.