



Referral for Evaluation or Treatment Services

Date of referral: _____

Referring physician/clinician: _____ Phone: _____

Client's Name: _____ Date of Birth: _____

Parent's or Guardian's Name(s): _____

Home phone: _____ Work/Cell phone: _____

Type of service you are interested in:

Educational Evaluation

Emotional / Behavioral Evaluation

ADHD Evaluation

Psychotherapy or Consultation

Please briefly describe the reason for referral: _____

What questions would you like answered by an evaluation (if referral is for evaluation):

1) _____

2) _____

3) _____

Consent for Release of Information

I, _____ (name of parent/guardian) give consent for the physician/clinician named above to transmit this form and the information it contains about myself and my child _____ (name of child), to Dr. Susan Anvin and Dr. Jenny Forman at Advancing Minds. This information is to be used for the sole purpose of facilitating a referral for additional services. I understand that I have no obligation to enter into any service with Advancing Minds, and that no further information will be communicated between my physician/clinician and Drs. Anvin and Forman without my knowledge and consent.

I wish for an Advancing Minds clinician to call me to discuss the services above

Best time/number to call: _____

I will call Advancing Minds myself and do not wish a clinician to contact me.

Name of Parent/Guardian

Signature of Parent/Guardian

Date