Referral for ADHD Assessment

Phone: 475-234-8700 Email: dr.jomary@jsbwellnessllc.com
Provider Name: Dr. Jomary Sepulveda, Licensed Psychologist

Referring Provider Information

Name: _____
Credentials/Title: _____
Practice/Agency Name: _____
Phone: _____ Fax: _____
Email: _____

Client Information

Client Name: _____
DOB: _____ Age: _____
Phone: _____ Email: _____
Legal Guardian (if applicable): _____

Referral Reason (Check all that apply):

☐ ADHD Evaluation (Teen or Adult)
☐ Second Opinion – ADHD Diagnosis
☐ Confirmation of Previous ADHD Diagnosis
☐ Diagnostic Clarification (ADHD vs. other concerns)
☐ Assessment to Support Treatment Planning
☐ Other: _____

Presenting Concerns / Relevant History:

(Brief summary of symptoms, concerns, or diagnostic questions)

_____

_____

Services Requested:

☐ ADHD Assessment (includes written report + feedback)
☐ Collaboration/Consultation with Referring Provider

Insurance Information (Optional if client will self-pay):

Insurance Provider: _____
Member ID #: _____
Policy Holder Name: _____
Photo ID & Insurance Card attached? ☐ Yes ☐ No

Legal / Safety Considerations:

Are there any legal concerns or court involvement (custody, disability claims, etc.)?
☐ No ☐ Yes – Please explain: _____

Referring Provider Signature: _____ Date: _____

Please attach:

- A copy of the client's ID
- Insurance card (front & back, if applicable)
- Any prior evaluations or relevant documentation (optional but helpful)