since 1995

PSYBAR®

Objective Opinions / Confident Decisions

PSYBAR REFERRAL FORM

IME_____ File Review_____ Co-Morbid File Review _____ Medical Records Request _____ FMLA _____

Type of Evaluation: Neuropsychological_____ Psychological_____ Psychiatric_____ Co-Morbid M.D. _____

Other (see attached list) _____

PATIENT/CLAIMANT INFORMATION

Patient's Last Name: First Middle				Has this person had Prior Mental Health Evaluation? ❑ No ❑Yes Date_____
Date of Injury:	❑Yes I have Medical Records to send with this exam. They are __ inches thick. ❑No I do not have Medical Records to send	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street Address:		Home Phone Number:		Alt. Phone Number:
P.O. Box:	City:		State:	ZIP Code:
Occupation:	Employer:			Employer Phone Number:
Mental Health Provider Name(s):	Mental Health Provider Address(s):			Mental Health Provider Phone Number(s):
Claim Number:				
Current Diagnosis:				

Attorney (Name, Address, Phone , Fax and E-mail):

CLIENT/CONTACT INFORMATION

Your Name:	Title:	Company Name and Address:	Phone Number:
E-mail Address:		Fax no.:	
Is this your first Referral to PsyBar?	❑ Yes ❑ No		

SPECIAL INSTRUCTIONS

Please Fax this form to: (952) 848-1798