



FICUS Center

Family Intervention Creates Unity and Strength



Psychological Evaluation Referral

Please complete this form and submit by one of the following methods; I will reply within two business days. Thank you!

~ fax: 540-572-4690 (include area code)

~ e-mail: debra@ficuscenter.com

~ mail: Debra Marks, PsyD
221 Albemarle Ave SW
Roanoke, VA 24016

Date: _____ Urgency: _____ (Date needed by _____)

Client Information

Name: _____ DOB: _____ Age: _____
First MI Last

Guardian: _____ Relation: _____
(If minor)

Client contact: Phone: _____ E-Mail: _____

Funding: Self Insurance CSA (Agency: _____)

Insurance Company: _____ ID # _____

Referral Information

Referred by: _____ Agency: _____

Phone: _____ Fax: _____ E-Mail: _____

Have any prior evaluations been completed? _____ Is a copy available? _____

Primary purpose of evaluation:

Cognitive Functioning _____ Personality Functioning _____

Interpersonal Functioning _____ Diagnostic Classification _____

Treatment Planning/Recommendations _____ Parental Capabilities _____

Other: _____

Known psychological, cognitive, behavioral, substance abuse issues:

Client's current services:

Outpatient Therapy - provider:
Intensive In-Home Services - provider:
Medication Management - provider:
Intensive Case Management - provider:
Therapeutic School Services - provider:
Therapeutic Mentoring - provider:
Adult Mental Health Worker - provider:
Substance Abuse Treatment - provider:
Probation/Outreach
Other:

Additional comments:

Thank you for this referral. I will be in contact with you shortly.