

Psychoeducational Screening Assessment

Trainee Self Referral Form

Please note that we reserve the right to refuse service at our discretion if we believe the required services fall outside our areas of service or competency areas, or if we feel there is any concern of potential risk or safety concern to our psychologists, staff or clients.

☐ I understand

* Indicates required question

DATE*			
RESIDENT'S FIRST AND LAST NAME			
PHONE NUMBER		EMAIL ADDRESS	
RESIDENT'S DATE OF BIRTH			
RESIDENT'S AGE			
SELF-IDENTIFIED GENDER			

WHAT ETHNIC OR CULTURAL ORIGINS BEST DESCRIBES YOU? (INPUT IN SPACE BELOW OR CHECK BOXES)		
	<input type="checkbox"/> UNKNOWN	<input type="checkbox"/> PREFER NOT TO ANSWER

LANGUAGES SPOKEN		
<input type="checkbox"/> ENGLISH	<input type="checkbox"/> FRENCH	<input type="checkbox"/> OTHER (INPUT BELOW)
LANGUAGES WRITTEN		
<input type="checkbox"/> ENGLISH	<input type="checkbox"/> FRENCH	<input type="checkbox"/> OTHER (INPUT BELOW)

Occupation/ School Information

CURRENT YEAR OF RESIDENCY	
AREA OF SPECIALTY	
WHERE WAS MEDICAL SCHOOL COMPLETED? (SCHOOL AND COUNTRY IF KNOWN)	
WHERE WAS UNDERGRADUATE TRAINING COMPLETED? (SCHOOL AND COUNTRY)	

Referral Information

REFERRAL SOURCE/ WHO IS SUGGESTING THIS ASSESSMENT?
IS AN INFORMAL OR FORMAL ENHANCED LEARNING PLAN (REMEDIATION) PLANNED OR IN PLACE?

ARE THERE ANY CONCERNS AROUND THE FOLLOWING:

** Check all that apply*

- ☐ 1. Learning (e.g. suspected or previously diagnosed Learning Disorder/ Learning Disability)
- ☐ 2. Cognitive (e.g. memory, executive functioning, language/ communication style)
- ☐ 3. Attention (e.g. suspected or previously diagnosed Attention-Deficit/ Hyperactivity Disorder)
- ☐ 4. Behaviour (e.g. emotional dysregulation, impulsivity)
- ☐ 5. Mental Health (e.g. depression, anxiety, OCD, etc...)
- ☐ 6. Suspected or previously diagnosed autism spectrum disorder
- ☐ 7. Trauma (e.g. complex trauma, PTSD)
- ☐ 8. Concussions or Traumatic Brain Injury
- ☐ 9. Other (answer in box on next page)

IF ANY CONCERNS ARE IDENTIFIED IN THE LIST ABOVE, PLEASE PROVIDE ADDITIONAL INFORMATION REGARDING EACH AREA OF CONCERN.

HAVE THERE BEEN ANY PREVIOUS ASSESSMENTS COMPLETED?
(I.E. PSYCHOEDUCATIONAL, NEUROPSYCHOLOGICAL, DIAGNOSTIC, SPEECH-LANGUAGE, ETC.)

☐ YES

☐ NO

IF 'YES' TO THE PREVIOUS QUESTION, HAVE ANY DIAGNOSES BEEN PROVIDED? PLEASE LIST

PLEASE DESCRIBE YOUR REASONS AND GOALS FOR THIS REFERRAL:

REASONS (E.G. FAILED REMEDIATION, DIFFICULTIES WITH LEARNING, COMMUNICATION ISSUES, ETC.)

GOALS FOR ASSESSMENT SERVICES (E.G. LEARNING SUPPORT, POSSIBLE ACCOMMODATIONS, ETC.)

OTHER INFORMATION –

PLEASE USE THIS SECTION TO PROVIDE ANY ADDITIONAL INFORMATION YOU MAY WISH TO SHARE WITH US

BY CHECKING THE BOX BELOW, I AM INDICATING THAT I UNDERSTAND THE ASSESSMENT MAY NOT LEAD A DIAGNOSIS AND/OR THE DIAGNOSIS MAY BE DIFFERENT THAN EXPECTED.

☐ I UNDERSTAND

A COLLATERAL SOURCE (PARENT, SIBLING, SPOUSE OR FRIEND) MAY BE REQUIRED FOR SOME OF OUR ASSESSMENTS. PLEASE NOTE THAT WE MAY NOT BE ABLE TO PROCEED IF THE RESIDENT CANNOT PROVIDE A COLLATERAL SOURCE.

* Check only one box

☐ I UNDERSTAND AND I HAVE A COLLATERAL SOURCE

☐ I UNDERSTAND BUT I DO NOT HAVE A COLLATERAL SOURCE

Cost And Insurance Information

THE HOURLY RATE FOR ASSESSMENT SERVICES IS \$225/HR. A COST ESTIMATE WILL BE PROVIDED IN ADVANCE BASED ON THE INTAKE INFORMATION PROVIDED.

Please note direct billing is not available. Following payment, we will provide a receipt to submit to the insurance company. Please view our webpage for more information about our fees as well as some questions to ask the insurance company. Information about third party coverage through Maritime Resident Doctors group benefits plan, visit <https://www.maritimeresidentdoctors.ca/starting-residency/group-benefits-101> (hyperlink)

BY CHECKING THE BOX BELOW, I UNDERSTAND THAT I AM RESPONSIBLE FOR DETERMINING WHAT INSURANCE COVERAGE I HAVE FOR ASSESSMENT/TREATMENT PRIOR TO MY APPOINTMENT. I UNDERSTAND THAT EBPS DOES NOT DO DIRECT BILLING AND THAT I WILL BE SUBMITTING A PAID INVOICE FOR SERVICES RENDERED TO MY INSURANCE PROVIDER FOR REIMBURSEMENT. THE FULL COST OF THE ASSESSMENT MAY NOT BE COVERED BY MY INSURANCE COMPANY.

☐ YES

Cancellation/ Credit Card Policy

Erica Baker Psychological Services LTD requires that you put a credit card on file to reserve your appointment. PLEASE NOTE THIS DOES NOT APPLY FOR THIRD PARTY PAYORS (e.g. Dalhousie)

A credit card is kept on file for your convenience or in the case of no-shows or late cancellations (see below).

MasterCard, Visa, AMEX, MasterCard Debit, and Visa Debit are accepted.

Inadequate notice of cancellation or not showing up for an appointment will result in a charge to your credit card. This equates to 20% of the cost of the in-person assessment day (5 hours); for interviews or feedback sessions the charge would be 50% of the cost of the session.

This charge is to offset the cost of our reserving the appointment time for you, the preparation time of the psychologist, and administrative costs that are incurred. Please note that your invoice will state "missed appointment" and most insurance companies will not reimburse for this cost.

Unpaid balances will be provided and billed to the credit card on the client's account outstanding balances are paid prior to further appointments being scheduled. Payments are to be made within 48 hours of service. If payment is not received within this time frame, the credit card on file will be processed.

Appointments can be rescheduled without a fee if there is a storm or sudden illness. Appointments for interviews or feedback questions sessions can be rescheduled or cancelled within the minimum of 24 hours notice.

We require a minimum of one weeks notice if you must reschedule or cancel your in-office assessment day. This allows us to offer the assessment date to an individual on our waiting list. Appointments can be cancelled by contacting your psychologist directly.

We will obtain a credit card number from you at the time of the intake call. This information will all be confidentially stored.

☐ By checking this box, I'm indicating that I'm aware of and agree to the Cancellation/ Credit Card Policy

Please return complete forms to Intake@ericabaker.ca