Center for Behavioral Health
University of Missouri – St. Louis

phone: (314) 516.4357
fax: (314) 516.4863
email: cbh@umsl.edu

12837 Flushing Meadows, Ste 220
Town & Country, Missouri 63131
www.umsl.edu/cbh

PSYCHOLOGICAL EVALUATION REFERRAL FORM

Child's Name: _____Date of referral: _____

Address: _____
(Street)

_____
(City, State Zip Code)

Date of Birth:_____ Sex:_____

Racial/Ethnic Background (Optional for Missouri Human Rights Compliance Report):
(please circle):

☐ Asian ☐ African-American ☐ Caucasian

☐ Native American ☐ Hispanic Other:_____

Legal Guardian(s):_____Relationship:_____

Guardian's Phone: (Cell) _____ Guardian aware of referral: yes / no

Guardian's Email: _____

Other important contacts:_____ Relationship:_____

Phone: (Cell) _____

School District:_____ School:_____

Grade_____

Referring Staff Member: _____Phone:_____

Referring Staff Member's relationship to child: _____

Briefly describe your reasons for requesting services for this student:_____

_____

_____

Please list any medications the child is taking, if any:_____

Upon completion, please fax this form to CBH Intake at 314-516-4863