

UNIVERSITY OF
LOUISVILLE
COLLEGE OF EDUCATION
& HUMAN DEVELOPMENT

**Cardinal Success Program
Student/Child/Adolescent Assessment Referral Form**

It is important that you communicate to the person you are referring your concerns and explain this referral to them. Please fill out this form and email it to ECPYCSP@louisville.edu.

Client's Name: _____ **Date of birth (or age if unknown):** _____
Legal Guardian's Name: _____
-Legal Guardian's Phone number: _____

Referred by: _____ **Date:** _____
-Phone number: _____

Has client had prior psychological testing? No | Yes | Unknown

-If yes, describe for what: _____

-Tests used: _____

Does student currently have an IEP? No | Yes | Unknown

Reason for current referral: *(Check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Intellectual ability (I.Q.,) | <input type="checkbox"/> Academic Motivation |
| <input type="checkbox"/> Academic achievement/learning disability | <input type="checkbox"/> Perception (Vision, audition, etc.) |
| <input type="checkbox"/> Attention, concentration, and/or hyper activity | <input type="checkbox"/> Traumatic brain injuries |
| <input type="checkbox"/> Motor functions (fine motor, motor learning) | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Autism-spectrum disorders | <input type="checkbox"/> Personality Traits |
| <input type="checkbox"/> Psychopathology (depression, anxiety, etc.) | <input type="checkbox"/> Other: _____ |

Referral questions *(What would you like to find out about the client or diagnostically rule out?)*

Comments: _____

Physiological health: _____

Current medications: _____

Are you also referring for counseling services? No | Yes | Defer to assessing clinician

-If yes, please additionally submit a Cardinal Success Student Assessment Referral Form.