PSYCHOLOGY PSYCHODIAGNOSTIC CLINIC

Name: _____ Date: _____

ID (prefix and sponsors SSN): _____

I am a (circle one): Inpatient on a psychiatric ward Outpatient

Age: _____ Date of birth: _____ Gender (circle one): Male Female

Ethnic background (circle one): Caucasian African American Hispanic

American Indian Asian Other: _____

Marital Status (circle one): Married (first marriage) Remarried Separated

Single, never married Single, previously married Widowed

Service Status (circle one): Active Duty Retired Reserves National Guard Family Member

Service Branch (circle one): Navy Marines Army Air Force Coast Guard Other: _____

AD or Retired Service Member/Sponsor Rank (e.g., E-4, O-1): _____

Years of education: _____

Academic degrees (e.g., High School Diploma, A.A. degree): _____

_____

Reason for this referral/current problem: _____

_____

_____

_____

Please read and sign

I understand that I have been referred for psychological testing to assist my mental health provider in clarifying diagnostic and treatment issues. I understand that the services provided by the Psychodiagnostic Clinic of the Psychology Department are limited to the reporting of objective test findings, and that I will not receive a full mental health work-up or ongoing psychological services through this clinic. However, I will be given feedback by the psychologist regarding the test results. I further understand that test results will be entered into my electronic medical record (AHLTA) and will be designated as "sensitive", which offers the highest level of privacy for this information. Lastly, I understand that if I feel I am in need of emergency mental health services at this time, I must inform clinic personnel of this fact so that I may be offered appropriate services.

Signature: _____ Date: _____