TO: Specialty/Service ADHD/LD Testing/Assessment

FROM: MU Student Health Center    Date: ________________

Tentative Diagnosis & Pertinent Clinical Data:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

REFERRAL REQUEST

____ Confirm Diagnosis
____ Suggest treatment and academic accommodations
____ Please fax written report to 573-884-1811

Provider Signature

Student Health Center
University of Missouri
1020 Hitt St.
Columbia, MO 65212
(573) 882-1483  Behavioral Health
(573)882-7481  Primary Care

ATTACHMENTS

____ Release of Information

____ Referral Form faxed to 573-884-3399 (fax #) on ________________ (date)

____ Copy in Chart

____ Copy to Behavioral Health

consref.frm. 05/16 pr