Psychological Evaluation Report Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A psychological evaluation report is the written product of psychological testing: it integrates the referral question, history, behavioral observations, and standardized test results into an interpretation, a diagnosis, and recommendations. It goes back to the referrer, and the patient will usually read it too.

Identifying information & referral question the question is the spine of the report
Do: state who the patient is, who referred them, and the specific question this evaluation exists to answer, in a sentence or two.
Pitfall: restating a vague "rule out everything" referral; interpretation with no target reads as testing for its own sake.

Notification & consent purpose, fees, limits, audience
Do: record what the patient was told about the purpose, the fees, confidentiality limits, and who receives the report.
Pitfall: silence about who gets the report; access disputes start exactly where the record says nothing.

Sources & tests administered instruments, records, and the clock
Do: list every instrument by full name, the interview and records reviewed, and the administration, scoring, and interpretation time.
Pitfall: omitting the hours; the US testing codes are time based, and unrecorded time cannot support the units billed.

Background history what bears on the question
Do: cover the developmental, medical, psychiatric, educational or work, family, and social history relevant to the referral question.
Pitfall: reprinting the intake; the report needs the history that matters here, not a second copy of the chart.

Behavioral observations & validity is the profile interpretable?
Do: describe presentation and engagement, then state explicitly whether effort and validity indicators support interpretation.
Pitfall: no validity statement; a reviewer who cannot tell whether results are valid cannot credit anything built on them.

Results & interpretation prose, not printouts
Do: organize findings by domain or instrument and put scores in context, integrated across measures.
Pitfall: pages of score tables with no narrative; payers pay for evaluation, and a score dump documents administration only.

Summary & clinical impressions one integrated picture
Do: pull interview, history, observations, and testing into one clinical picture that answers the referral question directly.
Pitfall: introducing new findings here; the summary integrates what the body of the report already shows.

Diagnostic impression a conclusion either way
Do: give the DSM-5-TR diagnosis with its ICD-10-CM code and rule-outs, or state that no diagnosis is supported and what justified testing.
Pitfall: skipping the line when testing is negative; policy expects the suspected diagnosis even when none is found.

Recommendations & sign-off the section everyone reads first
Do: number each recommendation, tie it to a finding, name a re-evaluation trigger, and sign with credentials (supervisor too, if required).
Pitfall: boilerplate advice that could follow any battery; generic recommendations waste the entire evaluation.

Before you sign

- [ ] Summary answers what the referrer asked
- [ ] Explicit statement on effort and validity
- [ ] Each score carries interpretation in prose
- [ ] Instrument names, dates, and hours recorded
- [ ] Conclusion follows the data, even if negative
- [ ] Every recommendation traces to a finding
- [ ] Credentials signed; supervisor where needed

Drafting with AI

Capture 30 seconds of bullets after scoring: referral question, instruments with key scores, validity note, relevant history, impression, recommendations.

> *"Draft a psychological evaluation report from these results, 29-year-old referred for diagnostic clarification of mood instability, PHQ-9 14, MDQ negative, MMPI-3 valid with demoralization elevated: …"*

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

3–12 pages	**2–6 hrs after testing**	**After a testing battery**	**Referrer · patient · schools · courts**
typical length	clinical team estimate	when it is written	who reads it

Full guide and sample report:
bastiongpt.com/template/psychological-evaluation-report

BastionGPT drafts the report from your scores and notes. Free 7-day trial.

Psychological Evaluation Report Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Patient (initials): | DOB / age: | Dates of service: | Report date:

Evaluator / credentials / license #: | Supervisor (if required): | Referral source:

Referral question
The specific question this evaluation should answer, in one or two sentences

Notification & consent
Purpose, fees, confidentiality limits, who receives the report; feedback session planned

Sources of information
Interview (date, length), records reviewed, collateral contacts

Tests administered
Full instrument names + administration, scoring & interpretation time

Background history
Relevant to the question: developmental / medical / psychiatric; educational / occupational; family / social

Behavioral observations & validity
Presentation, engagement, effort; explicit statement that results are (or are not) interpretable

Results & interpretation
By domain or instrument, scores in context, integrated in prose

Summary & clinical impressions
One integrated picture; answer the referral question directly

Diagnostic impression
DSM-5-TR / ICD-10-CM with rule-outs, or "no diagnosis supported" plus the suspected diagnosis that justified testing

Recommendations & re-evaluation trigger
Numbered, specific, tied to findings; what would prompt re-evaluation

Evaluator signature / credentials: | Supervisor signature (if required): | Date signed: