

SUBMIT TO:

Psychological and Neuropsychological Testing Request Form Please print clearly – incomplete or illegible forms will delay processing.

Member Information		Provider Informat		
Patient Name:		(Please indicate by check be authorized to the pro	king below, whether request ovider or agency.)	ed services should
Health Plan:		· ·		
DOB:			Name:	
SS#:		Professional Credentia	al: MD PhD 🗆	Other:
Patient ID#:		Physical Address:		
Referral Source:				
DSM IV Axis		PHONE:	FAX:	
AXIS I R/O	R/O	Medicaid/TPI/NPI#: _	Tax ID#	# :
AXIS II		IF ADJ ID is a discuss		laka sha fallai.a
AXIS III		IFADHD is a diagnostic rule out, please complete the following		
AXIS IV		Indicate name and res	sults of standardized ADH	ID Rating:
AXISV			e	
Has the patient had a psychiatric me		☐ Positive ☐ Nega	ative Inconclusive	☐ Not Applicable
☐ Yes ☐ No Date:	, -	If the patient is a child	, please indicate the colla	teral information
Results:		you have obtained fro	om the school regarding c er feedback, results from s	ognitive/academic
			criceaback, results from s	
If psychiatric medication evaluation current medications?	n was completed, what are the			
Medication:	Dose:	What are the referral	questions to be answere	d?
Medication:	Dose:			
Medication:	Dose:			
Was Previous Psychological Testir	g Conducted?			
Yes □ No Date:				
Basic Focus and Results:				
		Test	Hrs Requested	Hrs Approved
		icsc	Th's Requested	тизукриочес
What are the Current SympRequest for Testing? Anxiety Depression Self-Injurious Behavior Eating Disorder Symptoms Withdrawl/Poor Social Interaction Mood Instability Behavior Problems at School Bizarre Behavior				
☐ Unprovoked Agitation/Agression	☐ Hyperactivity			
Additonal Symptoms:			Total Hrs Approve	d