

## Request for Psychological Testing

Please complete all fields legibly. If incomplete or illegible, the form will be returned to you.

1. Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Plan: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

2. Referring Provider: \_\_\_\_\_ Tel #: \_\_\_\_\_

Provider to conduct testing: \_\_\_\_\_ Tel #: \_\_\_\_\_

3. Referral Question: \_\_\_\_\_

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4. Current Diagnosis:

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

5. Has an initial interview by the testing psychologist taken place? Please document findings of initial interview.

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6. List current symptomatology and length of time symptoms have been present.

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7. Has the patient been evaluated for medication? Please document results of that evaluation. If an evaluation has not occurred, indicate reason.

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8. Current Medications

<u>Name</u>	<u>Dosage</u>	<u>Start Date</u>

9. Previous Med Trials

<u>Name</u>	<u>Dosage</u>	<u>Start Date</u>

10. Current Treatment

- Individual Therapy    Provider: \_\_\_\_\_ Start Date: \_\_\_\_\_
- Medication Mgmt    Provider: \_\_\_\_\_ Start Date: \_\_\_\_\_
- Group Therapy    Provider: \_\_\_\_\_ Start Date: \_\_\_\_\_
- PHP/IOP    Provider/Facility: \_\_\_\_\_ Start Date: \_\_\_\_\_
- Other: Describe: \_\_\_\_\_

11. Past Treatment History

- Individual Therapy    Provider: \_\_\_\_\_ Duration D/C Date: \_\_\_\_\_
- Medication Mgmt    Provider: \_\_\_\_\_ Duration D/C Date: \_\_\_\_\_
- Group Therapy    Provider: \_\_\_\_\_ Duration D/C Date: \_\_\_\_\_
- PHP/IOP    Provider/Facility: \_\_\_\_\_ Duration D/C Date: \_\_\_\_\_
- Inpatient    Facility: \_\_\_\_\_ Duration D/C Date: \_\_\_\_\_

12. Previous Testing done:

Provider: \_\_\_\_\_ Date of Testing: \_\_\_\_\_  
 Results: \_\_\_\_\_

If previous testing has not been reviewed, indicate why not: \_\_\_\_\_

13. Current Testing:

Test Name: \_\_\_\_\_ Time Requested: \_\_\_\_\_  
 Total # of hours requested: \_\_\_\_\_

14. Signature of Requesting Psychologist: \_\_\_\_\_

Date: \_\_\_\_\_

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For BHC use only:

⊖ # of hours authorized \_\_\_\_\_

⊖ Denied. Specific reason for denial: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Denial letter to follow within one day of this notification)

Name of MD/PhD reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_