

# Psychological/Neuropsychological Testing Request

Treatment requests must be documented in whole hours and assessments must justify the clinical need for all tests requested.

Testing will not be authorized under any of the following conditions:

1. The referral question can be answered through a comprehensive diagnostic interview and/or routine screening or assessment measure (e.g. self-report inventories, rating scales).
2. Testing is not directly relevant or necessary for proper diagnosis and/or development of a treatment plan for a behavioral health disorder or associated medical condition.
3. Testing is primarily for educational, vocational or legal purposes.
4. Testing is routine for entrance into a treatment program.
5. The tests requested are experimental or have no documented validity.
6. The time requested to administer the testing exceeds established time parameters.

<b>Demographic information</b>		
Patient name:	DOB:	Age:
Referral source:	Medicaid ID/SS #/Patient ID:	
<b>Provider information</b>		
Provider name:	Agency name:	
Professional credential: <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> Other:	Address:	
Phone:	Fax:	Medicaid/NPI/Tax ID:
Date of diagnostic interview/intake:		
Please attach a summary of the diagnostic interview, including scores from screening tools used.		
Behavioral and medical diagnoses:		
Specific referral reason/question:		
State how the anticipated results of the testing will affect the patient's treatment plan:		
Was a substance abuse assessment completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Results (or attach the results to this request):	
Has previous psychological or neuropsychological testing been conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please give details to include tests that have been conducted, when they were completed, and reason for testing:		

# Psychological/Neuropsychological Testing Request

Medications			
Medication name	Dose/frequency	Start date	Prescribing provider

  

Testing request			
Start date	Stop date	CPT code	Units requested

  

Please indicate the tests planned to answer the clinical questions			
<input type="checkbox"/> WISC (120 min.)	<input type="checkbox"/> MMPI-A (60 min.)	<input type="checkbox"/> ADOS (120 min.)	<input type="checkbox"/> BRIEF (60 min.)
<input type="checkbox"/> WAIS (120 min.)	<input type="checkbox"/> MACI (60 min.)	<input type="checkbox"/> Conner's Continuous Performance (60 min.)	<input type="checkbox"/> Conner's Continuous Performance – Kiddie (30 min.)
<input type="checkbox"/> WPPSI (120 min.)	<input type="checkbox"/> NEPSY (60 min.)	<input type="checkbox"/> Vineland (60 min.)	<input type="checkbox"/> MAPI (60 min.)
<input type="checkbox"/> MMPI (60 min.)	<input type="checkbox"/> PAI (60 min.)	<input type="checkbox"/> DAS (60 min.)	
<input type="checkbox"/> BASC/CBCL (30 min. each): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Teacher <input type="checkbox"/> Other	<input type="checkbox"/> Autism Checklist (15 min. each): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Teacher <input type="checkbox"/> Other	<input type="checkbox"/> ADHD Checklist (15 min. each): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Teacher <input type="checkbox"/> Other	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

If you are requesting more time for a test than is the standard allowed time, please indicate the reason:

Additional comments:

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_