OUTPATIENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Date ________________________________

<table>
<thead>
<tr>
<th>PATIENT INFORMATION</th>
<th>PROVIDER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name _______________________________</td>
<td>Provider Name _______</td>
</tr>
<tr>
<td>Date of Birth ______________________</td>
<td>Group Name _________</td>
</tr>
<tr>
<td>Patient ID # _______________________</td>
<td>Provider NPI/TIN # _______</td>
</tr>
<tr>
<td>Referral Source _____________________</td>
<td>Phone _______________ Fax ______________</td>
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CURRENT ICD DIAGNOSIS

*The provider must report all diagnoses being considered for this patient.

*Primary ___________________________________________________ R/O ____________________________________

Secondary __________________________________________________________

Tertiary __________________________________________________________

Additional __________________________________________________________

Additional __________________________________________________________

Danger to Self or Others (If yes, please explain)? □ Yes □ No

____________________________________________________________________________________

MSE Within Normal Limits (If no, please explain)? □ Yes □ No

____________________________________________________________________________________

WHAT ARE THE CURRENT SYMPTOMS PROMPTING THE REQUEST FOR TESTING?

☐ Anxiety ☐ Self-injurious Behavior ☐ Other

☐ Depression ☐ Eating disorder symptoms: ______________________________

☐Withdrawn/poor social interaction ☐ Poor academic performance

☐ Mood instability ☐ Behavior problems at home

☐ Psychosis/Hallucinations ☐ Behavior problems at school

☐ Bizarre Behavior ☐ Inattention

☐ Unprovoked agitation/aggression ☐ Hyperactivity

What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information? How will testing affect the care and treatment in a meaningful way?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
HISTORY

Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures in the past?

☐ Yes  ☐ No  ☐ Uncertain  Comments: __________________________________________________________________________________________

Does the patient have a family history of psychiatric disorders, behavior problems or substance use disorder?

☐ Yes  ☐ No  ☐ Uncertain  Comments: __________________________________________________________________________________________

Is there any known or suspected history of physical or sexual abuse or neglect?

☐ Yes  ☐ No  ☐ Uncertain  Comments: __________________________________________________________________________________________

If ADHD is a diagnostic rule out, please complete the following: Is the patient’s presentation on intake consistent with ADHD?

☐ Yes  ☐ No

Indicate the results of Conner’s or similar ADHD rating scales, if given:

☐ Positive  ☐ Negative  ☐ Inconclusive  ☐ N/A

Date of Diagnostic Interview: _______________________________________________________________________________________________________

Has the patient had a Psychiatric Evaluation?  ☐ Yes  ☐ No  If yes, date? _______________________________________________________________________________

Previous Psychological Testing?  ☐ Yes  ☐ No  If yes, date? _______________________________________________________________________________

Basic Focus and Results ___________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________

Current Psychotropic Medications: ___________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________

PLEASE LIST THE TESTS PLANNED TO ANSWER THE CLINICAL QUESTION(S)

1. _______________________________________________________________  4. _______________________________________________________________

2. _______________________________________________________________  5. _______________________________________________________________

3. _______________________________________________________________  6. _______________________________________________________________

PLEASE INDICATE THE NUMBER OF UNITS REQUESTED TO COMPLETE TESTS:

_________________________________________________________________________________________________________________________________

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

_________________________________________________________________________________________________________________________________

Clinician  Printed Name Date  Clinician Signature Date

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SUBMIT TO
Utilization Management Department
Phone: 1.877.647.4848  Fax: 1.866.694.3649