SUBMIT TO
Utilization Management Department
Phone: 1.877.647.4848 Fax: 1.866.694.3649

INPATIENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

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

Date_____

PATIENT INFORMATION

Name _____

Date of Birth_____

Patient ID #_____

Referral Source _____

PROVIDER INFORMATION

Provider Name _____

Group Name _____

Provider NPI/TIN #_____

Phone_____Fax _____

CURRENT ICD DIAGNOSIS

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

*Primary_____R/O_____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
- ☐ Depression
- ☐ Withdrawn/poor social interaction
- ☐ Mood instability
- ☐ Psychosis/Hallucinations
- ☐ Bizarre Behavior
- ☐ Unprovoked agitation/aggression
- ☐ Self-injurious Behavior
- ☐ Eating disorder symptoms:
- ☐ _____
- ☐ Poor academic performance
- ☐ Behavior problems at home
- ☐ Behavior problems at school
- ☐ Inattention
- ☐ Other _____

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?

1016.MM.P.FO 12/16

HISTORY

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

☐ Yes ☐ No 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

If the patient is a child, please indicate the collateral information you have obtained from the school regarding cognitive/academic functioniing (ie.,teacher feedback, results of school standardized testing) ? _____

_____

DateofDiagnoticInterview:_____

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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