NEUROPSYCHOLOGICAL TESTING REQUEST FORM

THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc.

This form should be completed by the provider who has knowledge of the enrollee's current clinical presentation and his/her treatment history. **Please provide copies of any materials that will be helpful in reviewing this request for approval.**

DATE OF REQUEST:	
PROVIDER	**MEMBER**
Name of Provider Requesting Testing: **Phone:** **Fax:** **Email:**	**Member Name:** ☐ **Male** ☐ **Female**
Name of Provider to Complete Requested Testing: **Phone:** **Fax:** **Email:**	**Member ID:** **DOB:**

Patient Diagnoses *(current)*

Psychiatric

Medical

What neurological/neuropsychological disorder is suspected or has been confirmed?	
Description of symptoms and functional impairment (cognitive or otherwise).	
Relevant patient history (attach additional sheets as needed).	

Testing History

☐ No previous testing
☐ Previous testing performed (give dates, results, and reason for testing at this time)

Current Medications:	
Substance abuse history: *Substance?* *Last Use?*	
What is the specific question the testing is intended to answer?	
How will treatment plan be affected by test results/What action will be taken?	

Signature of Requesting Provider: Date: