# PSYCHOLOGICAL 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.** Submit to the Authorization Central Line **Fax: 202-721-7190** or email: **UMRequests@hschealth.org**.

| **DATE OF REQUEST:** | |
|---|---|
| **PROVIDER** | **MEMBER** |
| **Name of Provider Requesting Testing:**<br><br>**Phone:** **Fax:** | **Member Name:**<br><br>☐ **Male** ☐ **Female** |
| **Name of Provider to Complete Requested Testing:**<br><br>**Phone:** **Fax:** | **Member ID:** **DOB:** |

| ***Patient Diagnosis*** *(current)* | |
|---|---|
| Primary diagnosis | |
| Co-occurring psychiatric diagnoses | |
| Co-occurring medical diagnoses | |
| ***Description of symptoms and functional impairment*** | |

| ***History*** *(attach additional sheets as needed)* | |
|---|---|
| Patient psychiatric and medical history | |
| Relevant family and medical history | |
| History of psychological testing and results | |

| ***Assessment to date*** | |
|---|---|
| ☐ No assessment procedures performed to date<br>☐ Structured interview<br>☐ Direct observation<br>☐ Brief inventories or rating scales<br>☐ Medical evaluation<br>☐ Review of records of previous treatment/testing | ☐ Clinical interview with patient<br>☐ Interview with family<br>☐ Consultation with primary support groups<br>☐ Assessment by other mental health professional<br>☐ Consultation with patient's physician (current or past) |
| ***Test(s) to be administered and number of hours requested*** | |
| ***Is patient on medication? If so, what medication?*** | |
| ***Specific question testing is intended to answer*** | |
| ***How will treatment plan be affected by test results/What action will be taken?*** | |

Signature of Requesting Provider: Date: