Psychological/Neuropsychological Evaluation Request Form

A.

____ ________________________________
Patient Name Date of Birth

B.

____ ________________________________
Name and Credentials of Psychologist Agency

____ ________________________________
Telephone Number Email Address

C.

(i.) Who initiated referral (If MD, what s MD's specialty?

____
____
____

(ii.) Current symptoms and duration of symptoms:

____
____
____

(iii.) What are the referral questions and why is testing being requested at this time?

____
____
____

(iv.) Has patient been evaluated by a psychiatrist? _____ Yes _____No

If Yes, when? ____________________________

Current Medications:

____
____

D. Current possible DSM-5 Diagnosis under evaluation:

1.___________________________ 2._____________________________ 3.______________________________

Medical Diagnosis:

1.___________________________ 2.____________________________ 3.________________________________

Social Elements Impacting Diagnosis

1.___________________________ 2.____________________________ 3.________________________________

Optional Functional Assessment:_____________________________ Score:________________________

E. History of patient *(Summary of psychosocial and medical information and past treatment: include any past psychological testing, date and results, medical, psychiatric and neurological exam):*

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F. Describe how proposed testing will enhance treatment and impact future behavioral treatment:

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____

Is patient currently in treatment? _____yes _____no

If yes, specify modality e.g. (individual, group, family) ________________________________

G. Are there other explanations of current behaviors/symptoms? (i.e. thyroid dysfunction, closed head injury, medications, poisoning, etc.) Yes/No Explain:

____

____

H. List test(s) planned and time required. *(Note: time required for each test should include administration, scoring and interpretation and brief write-up)*

Specific Test(s) Planned	**Hours Requested**
____	_____________
____	_____________
____	_____________
____	_____________
____	_____________

Note: See SWMBH Medical Necessity Criteria (Adopted Beacon Health Options) for complete testing guidelines/criteria.

______________________	___________________________	_______________
Proposed Start Date	Signature of Psychologist	Date

Fax completed request form to 269-441-1234