



Every field must be completed in order to expedite review. Please type or print neatly. Please mail or fax completed Form to the following:

IMHS  
Attn: Utilization Management Department  
504 Lavaca St., Ste. 850  
Austin, TX 78701  
Fax: 866-694-3649

## I. Identifying Information

Member Name: _____	Member ID: _____	DOB: _____
Provider Name: _____	Group/Practice Name: _____	
Provider Phone: _____	Provider Fax: _____	
Referral Source: _____		

## II. Provisional DSM-IV Diagnosis (Please Note: *You must report all diagnoses being considered for this Member.*)

Axis I _____	R/O _____	R/O _____
Axis II _____		
Axis III _____		
Axis IV _____		
Axis V _____		
<b>Danger to Self or Others?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If "Yes", please explain:</b> _____ _____		
<b>MSE Within Normal Limits?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If "NO", please explain:</b> _____ _____		

## III. What are the current symptoms prompting the request for testing?

<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bizarre Behavior <input type="checkbox"/> Mood Instability <input type="checkbox"/> Inattention	<input type="checkbox"/> Self-injurious Behavior <input type="checkbox"/> Eating Disorder Symptoms <input type="checkbox"/> Withdrawn/Poor Social Interaction <input type="checkbox"/> Psychosis/Hallucinations <input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Behavior Problems at Home <input type="checkbox"/> Behavior Problems at School <input type="checkbox"/> Poor Academic Performance <input type="checkbox"/> Unprovoked Agitation/Aggression <input type="checkbox"/> Other: _____
_____		

## IV. 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?

<b>Comments:</b>  
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## V. History

1. Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures in the past?  Yes  No

Comments: \_\_\_\_\_

2. Does the patient have a family history of psychiatric disorders, behavior problems or substance abuse?  Yes  No  Uncertain

Comments: \_\_\_\_\_

3. Is there any known or suspected history of physical or sexual abuse or neglect?  Yes  No  Uncertain

Comments: \_\_\_\_\_

4. If ADHD is a diagnostic rule out, please complete the following: Is the Member's presentation on intake consistent with ADHD?  Yes  No

5. Indicate the results of Conner's or similar ADHD rating scales, if given:  Positive  Negative  Inconclusive  NA

6. If the patient is a child, please indicate the collateral information you have obtained from the school regarding cognitive/academic functioning (i.e., teacher feedback, results of school standardized testing).

Comments: \_\_\_\_\_

7. Date of Diagnostic Interview: \_\_\_\_\_

8. Has the patient had a Psychiatric Evaluation?  Yes  No

If "Yes", what was the date of the interview: \_\_\_\_\_

9. Previous Psychological Testing?  Yes  No

If "Yes", what was the date of testing: \_\_\_\_\_

Basic Focus and Results: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

10. Current Psychotropic Medications: \_\_\_\_\_

## VI. Please List the Tests Planned to Answer the Clinical Question(s)

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

VII. Please indicate the number of units requested to complete tests: \_\_\_\_\_

Network Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_