



Cenpatico Psychological Testing Authorization Request Form
INPATIENT

***ALL FIELDS MUST BE COMPLETED FOR THIS REQUEST TO BE REVIEWED
(Please type or print neatly)**

I. Identifying Information

Patient's Name: _____ PT. ID# _____ DOB: _____
Provider's Name: _____ Group Name: _____
Provider's Phone Number: _____ Fax: _____
Referral Source: _____

II. Provisional DSM-IV Diagnosis – *The provider must report all diagnoses being considered for this patient.

* Axis I _____ R/O _____ R/O _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

Danger to Self or Others (If yes, please explain)? YES NO _____

MSE Within Normal Limits (If no, please explain)? YES NO _____

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

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self-injurious Behavior | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Eating disorder symptoms: _____ | |
| <input type="checkbox"/> Withdrawn/poor social interaction | <input type="checkbox"/> Poor academic performance | |
| <input type="checkbox"/> Mood instability | <input type="checkbox"/> Behavior problems at home | |
| <input type="checkbox"/> Psychosis/Hallucinations | <input type="checkbox"/> Behavior problems at school | |
| <input type="checkbox"/> Bizarre Behavior | <input type="checkbox"/> Inattention | |
| <input type="checkbox"/> Unprovoked agitation/aggression | <input type="checkbox"/> Hyperactivity | |

SUBMIT TO:
Utilization Management Department
504 Lavaca, Suite 850, Austin, TX 78701
Phone: 800-947-0633
Fax: 866-694-3649

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? _____

V. 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 abuse?
 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 functioning (i.e., teacher feedback, results of school standardized testing)?

Date of Diagnostic Interview: _____

Has the patient had a Psychiatric Evaluation? YES NO
If yes, date of the interview: _____

Previous Psychological Testing? YES NO
If yes, date? _____

Basic Focus and Results: _____

Current Psychotropic Medications: _____

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

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

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

_____ _____ _____	_____ _____ _____
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Clinician's Signature/Title

Date

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