



INPATIENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Date _____

PATIENT INFORMATION

PROVIDER INFORMATION

Name _____

Provider Name _____

Date of Birth _____

Group Name _____

Patient ID # _____

Provider NPI/TIN # _____

Referral Source _____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

The provider must report all diagnoses being considered for this patient.

*Primary _____ R/O _____ R/O _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Danger to Self or Others (If yes, please explain)? Yes No _____

MSE Within Normal Limits (If no, please explain)? Yes No _____

WHAT ARE THE CURRENT SYMPTOMS PROMPTING THE REQUEST FOR TESTING?

- Anxiety
- Depression
- Withdrawn/poor social interaction
- Mood instability
- Psychosis/Hallucinations
- Bizarre Behavior
- Unprovoked agitation/aggression
- Self-injurious Behavior
- Eating disorder symptoms: _____
- _____
- Poor academic performance
- Behavior problems at home
- Behavior problems at school
- Inattention
- Other _____
- _____
- _____

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?

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 use disorder?

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 (ie., teacher feedback, results of school standardized testing) ? _____

Date of Diagnostic Interview: _____

Has the patient had a Psychiatric Evaluation? Yes No If yes, date? _____

Previous Psychological Testing? Yes No If yes, date? _____

Basic Focus and Results _____

Current Psychotropic Medications: _____

PLEASE LIST THE TESTS PLANNED TO ANSWER THE CLINICAL QUESTION(S)

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

PLEASE INDICATE THE NUMBER OF UNITS REQUESTED TO COMPLETE TESTS:

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

Clinician Printed Name

Date

Clinician Signature

Date

SUBMIT TO
Utilization Management Department
 12515-8 Research Blvd., Suite 400
 Austin, Texas 78759
 PHONE 1.877.647.4848 | FAX 1.866.694.3649