



Psychological/Neurological Testing Request Form

1. Name of Member: _____
2. How long has the Member been in therapy: _____
3. Current Diagnosis: _____
4. What is the specific referral question/What question are you hoping to answer through testing: _____

5. What are the current symptoms the Member is experiencing: _____

6. Which areas are these symptoms negatively effecting:
Work___School___Social___ Other___If other please explain: _____
7. When did these symptoms begin: _____
8. How long has the Member had these symptoms: _____
9. S/I___ H/I___ A/H___ V/H___ if yes to any please explain: _____

10. Is the Member currently taking any mind altering substances: Yes _____ no _____
(Member must be clean from substances for 60-90 days prior to testing)
 - a. If yes please explain: _____
11. What is the current treatment plan: _____
12. How will testing change treatment: _____

13. Can any of these tests be performed at another setting: School ___ IRC ___ other _____

14. Testing Information:

Name of Test	Rationale for test	Testing/Scoring time