

NEUROPSYCHOLOGICAL TESTING REQUEST

FAX to: Network Health Plan 920-720-1903

1. Member Name: _____ DOB: _____
Age: _____ Gender: _____ NHP Member number: _____

Testing Psychologist Name: _____ Phone () _____ Fax () _____
Date of Initial Assessment: _____ Referral Source: _____

2. Choose A or B:

A. Acute brain insult/Pervasive Developmental Disorder suspected/confirmed:

- Traumatic brain injury
 - _confirmed by imaging dated _____
 - _history of head injury **with** loss of consciousness/post-traumatic amnesia
- Anoxic/hypoxic brain injury
- History of intracranial surgery
- Confirmed neurotoxin exposure
- Cerebrovascular accident
- Encephalitis
- Pervasive developmental disorder

Testing History:

- No previous testing **and** cognitive impairment suspected/evident
- Previous testing performed **and** neurologic deficit confirmed
 - _unexpected change in symptoms within last 4 mo **and** no more than 1 testing episode within last 12 mo.
 - _retesting planned to evaluate response to new treatment **and** no more than 1 testing episode within last 12 mo.
 - _retesting planned to assess functioning
 - _1 previous episode of testing **and** no testing within last 6 mo.
 - _ at least 2 previous episodes of testing **and** no testing within last 3 yrs

B. Other Neurologic condition:

- Condition:
 - _Brain tumor in remission/ with slow progression
 - _Cerebral palsy/Static encephalopathy
 - _Epilepsy diagnosed **and** seizures at least 1x/mo
 - _Hydrocephalus **with** shunt placement
 - _Language disorder suspected/diagnosed
 - _Multiple sclerosis suspected/confirmed

- Cognitive impairment suspected/confirmed

Testing History:

- No previous testing
- Previous testing performed:
 - _unexpected change in symptoms within last 4 mo **and** no more than 1 testing episode within last 12 mo.
 - _retesting planned to evaluate response to new treatment **and** no more than 1 testing episode within last 12 mo.
 - _retesting planned to assess functioning:
 - _1 previous episode of testing **and** no testing within last 12mo.
 - _ at least 2 previous episodes of testing **and** no testing within last 3 yrs

3. Medication/Substance Use will not confound results:

- Patient on medication **and** drug effects ruled out of cause of cognitive impairment
- Substance abuse/dependence **and** at least 10 days sobriety
- No medication/substance use

4. Hours Requested: CPT 96118 _____ hrs CPT 96119 _____ hrs CPT 96120 _____ hrs
Test Checklist Attached: Addtl Info Attached: