PSYCHOLOGICAL TESTING REQUEST CHECKLIST

FAX to: Network Health Plan **920-720-1903**

Member Name:__________________ DOB:______________

Testing Psychologist Name: ___________________Phone (   ) ________ Fax (   ) ________

Who referred this patient to you?____

What was the identified goal for this referral? ____
____

Date of Initial Assessment: _____________

	Please fill out boxes 1-5 and answer questions 6-8. The following information is required for the secondary review to take place. The review can not begin until all of the listed information is submitted to Network Health Plan.	Check here if Included as attachments
1	Patient Demographics: Male☐ Female☐ Age _______	☐
2	Patient Diagnosis:	☐
3	Description of symptoms ***and*** functional impairment:	☐
4	History: ▪ patient psychiatric/medical ▪ family psychiatric/medical (if applicable) ▪ psychological testing ***and*** results/findings	☐
5	Assessment to date: ☐ clinical interview with patient ☐ interview with family ☐ direct observation of parent-child interactions ☐ consultation with school/other caregiver ☐ brief inventories or rating scales ☐ assessment by another mental health professional ☐ consultation with pediatrician ☐ review of records No assessment completed to date ☐	☐

6. What specific question (s) is the testing intended to answer?

7. What action will be taken /How will treatment for this member be changed based on the results?

8. Hours requested : CPT 96101 ____ CPT 96102 ____ CPT 96103 ____

Please see checklist of tests to be administered ☐
Or List below the test (s) to be administered: