Neuropsychological Testing Request Form

Patient Name:_____Patient Phone #:_____

DOB:_____ Age:_____ Gender:_____ID#:_____

Provider Name:_____ License:_____

Provider Tax ID#:_____Tel #:_____Fax #:_____

ALL QUESTIONS MUST BE ANSWERED FOR THIS REQUEST TO BE CONSIDERED

A medical or neurological evaluation must have been completed within the past 6 months. This is required prior to requesting neuropsychological testing approval.

- Name and specialty of the referring provider:
- Date of evaluation or date of last visit:

Prior to requesting testing, a thorough clinical interview with the patient and/or the parents of a child and a review of history of previous treatment and testing should be completed, including consultation with current or recent providers.

- Date of your completed diagnostic interview (CPT 90791):

Patient's psychiatric and substance abuse history and current psychiatric/substance abuse diagnoses (including all rule outs):

Patient's medical history and current medical diagnoses (including all rule outs):

History of previous testing and results/findings: (include dates of testing)

History of previous treatment for the current medical and psychiatric/substance abuse issues and treatment outcome:

Description of current symptoms and functional impairment:

If ADHD is a diagnostic rule out, please complete the following:

1. Is the patient's presentation on intake consistent with ADHD? Yes No
2. Indicate the results of Conner's or similar ADHD rating scales, if given:
   Positive Negative Inconclusive N/A

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Please explain why neuropsychological testing is medically necessary for the patient:

The test(s) to be administered and number of hours requested:

Name of Test	# of Hours Needed
TOTAL HOURS:	

(*MHN authorizes industry standard time allowances)

Psychologist's Signature:_____ **Date:**_____

SEND REQUEST FORM TO MHN
Fax: 855-661-0077
Attention: Testing Coordinator