PPM-Part 3
C.1-Entire form applicabe for accessing testing

Psychological Testing Request Form

MHN
www.mhn.com

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

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.

- Who initiated the referral (PCP, neurologist, therapist, psychiatrist, parent, teacher)?
- Is the request court ordered or required for placement? ☐ Yes ☐ No
  - If yes, please explain:
- Date of your completed diagnostic interview (CPT 90791):

Patient's psychiatric history:

Patient's medical history:

Family's psychiatric history:

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

Has the patient been evaluated or classified by the school system? (child/adolescent only)

Please list the name of completed inventories and/or scales and results: (e.g. Beck Depression Inventory)
****At least 1 validated symptom inventory or scale should be completed during assessment proves prior to requesting psychological testing.****

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One of the following criteria MUST be met:

1. Testing is required for differential diagnostic clarification. An accurate diagnosis cannot be made despite a licensed mental health professional completing a thorough mental health assessment, using DSM criteria and the use of symptom inventories. ☐ Yes ☐ No
   If Yes, please explain:

   a. Description of current symptoms and functional impairment:

   b. Current primary diagnoses:

   c. Rule out diagnoses:

   d. Co-occurring substance abuse diagnoses:

   e. Co-occurring medical diagnoses:

   f. Danger to self/others? ☐ Yes ☐ No
      If yes, please explain:

   g. If ADHD is a diagnostic rule out, please complete the following:
      i. Is the patient's presentation on intake consistent with ADHD? ☐ Yes ☐ No
      ii. Indicate the results of Conner's or similar ADHD rating scales, if given:
      ☐ Positive ☐ Negative ☐ Inconclusive ☐ N/A

2. Results of testing are required to formulate a treatment plan or are required to make necessary revisions to an existing treatment plan. ☐ Yes ☐ No
   If Yes, please explain. What was previous treatment, if any?

3. The member has received previous treatment and the treatment response is significantly different from the expected response based on the treatment plan. ☐ Yes ☐ No
   If Yes, please explain previous response to treatment:

4. It is necessary to evaluate a member's functional capacity to participate in behavioral health treatment. ☐ Yes ☐ No
   If Yes, please explain:

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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