THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc. (HSCSN)

NEUROPSYCHOLOGICAL TESTING REQUEST FORM

This form should be completed by the provider who has knowledge of the enrollee's current clinical presentation and his/her treatment history. **Please provide copies of any materials that will be helpful in reviewing this request.**

Date of Request:		
Enrollee Name:	Enrollee ID Number:	DOB: Circle: M☐ F☐
Name of Provider requesting testing:		Phone:
Name of Provider to complete requested testing:		Phone:

Patient Diagnosis *(current)*

Primary diagnosis	
Co-occurring psychiatric diagnoses	
Co-occurring medical diagnoses	
What neurological/neuropsychological disorder is suspected or has been confirmed?	
Description of symptoms and functional impairment (cognitive or otherwise).	
Relevant patient history (attach additional sheets as needed).	

Testing History

☐ No previous testing
☐ Previous testing performed (give dates , results, and reason for testing at this time)

_____
_____
_____

Is patient on medication? *If so, what medication?*	
Does the patient have a substance abuse problem? *If so, what was the date of last use?*	
Specific question testing is intended to answer?	
How will treatment plan be affected by test results/What action will be taken?	

Signature of requesting provider: _____Date: _____

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