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

PSYCHOLOGICAL 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	
Description of symptoms and functional impairment	
History *(attach additional sheets as needed)*	
Patient psychiatric and medical history	
Relevant family and medical history	
History of psychological testing and results	

Assessment to date

- ☐ No assessment procedures performed to date
- ☐ Structured interview
- ☐ Direct observation
- ☐ Brief inventories or rating scales
- ☐ Medical evaluation
- ☐ Review of records of previous treatment/testing
- ☐ Clinical interview with patient
- ☐ Interview with family
- ☐ Consultation with primary support groups
- ☐ Assessment by other mental health professional
- ☐ Consultation with patient's physician (current or past)

Test(s) to be administered and number of hours requested	
Is patient on medication? If so, what medication?	
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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