



Empire Utilization Management Services  
PO Box 2100  
NorthHaven, CT 06473

Fax: (800) 265-9866

## Request for Neuropsychological/Psychological Testing

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Patient Information (must be completed):

<b>Patient Name:</b> _____	<b>Date of Birth:</b> _____
<b>ID #:</b> _____	<b>Subscriber Name:</b> _____

Provider Information:

Provider Requesting Testing: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

<b>Provider to Administer Testing:</b> _____
<b>Address:</b> _____ <b>Phone:</b> _____
_____ <b>Fax:</b> _____

Clinical Information:

<b>Current Diagnosis (DSM IV) :</b>	<b>Axis I</b> _____	<b>Description</b> _____
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Axis II \_\_\_\_\_ Description \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_

Current GAF \_\_\_\_\_ Highest Past Year \_\_\_\_\_

Has patient recently been in treatment? \_\_\_\_\_ How long and with whom? \_\_\_\_\_

Current psychotropic medications: \_\_\_\_\_

Previous psychotropic medications: \_\_\_\_\_

**(Please proceed to next page)**

**Request for Psychological Testing continued...**

What current symptoms or conditions suggest the need for testing? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the patient had any previous testing? (If so, please include dates, tests administered and results) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specific questions to be answered by testing: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe how the testing is necessary for diagnosing and treating the patient: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Test Proposed:

Name of Test	Purpose	Time Needed	Procedure Code
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Projected Date of Testing:** \_\_\_\_\_

**Signature of Provider (completing form):** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Address/Phone/Fax (if different from providers on front):**  
\_\_\_\_\_