Psychological/Neurological Testing Request Form

1. Name of Member: _____
2. How long has the Member been in therapy: _____
3. Current Diagnosis: _____
4. What is the specific referral question/What question are you hoping to answer through testing:_____

   _____

   _____
5. What are the current symptoms the Member is experiencing:

   _____

   _____
6. Which areas are these symptoms negatively effecting:

   Work___School___Social___ Other___If other please explain: _____
7. When did these symptoms begin:_____
8. How long has the Member had these symptoms:_____
9. S/I____ H/I____ A/H____V/H____ if yes to any please explain:_____

   _____
10. Is the Member currently taking any mind altering substances: Yes _____ no_____ (Member must be clean from substances for 60-90 days prior to testing)

    a. If yes please explain:_____
11. What is the current treatment plan:_____
12. How will testing change treatment:

    _____

    _____
13. Can any of these tests be performed at another setting: School___IRC___other_____
14. Testing Information:

Name of Test	Rationale for test	Testing/Scoring time