SUBMIT TO
Utilization Management Department
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
Phone: 1.800.704.1483
FAX: 1.844.263.1379

INPATIENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Date ____

PATIENT INFORMATION

Name____

Date of Birth ____

Patient ID # ____

Referral Source ____

PROVIDER INFORMATION

Provider Name ____

Group Name ____

Phone _________________________Fax __________________

CURRENT ICD DIAGNOSIS

*The provider must report all diagnoses being considered for this patient.

Primary ___________________________________ R/O ___________________________________ R/O _________________________________

Secondary ____

Tertiary ____

Additional ____

Additional ____

Danger to Self or others (If yes, please explain)? ❑ Yes ❑ No ____

____

MSE Within Normal Limits (If no, please explain)? ❑ Yes ❑ No

____

WHAT ARE THE CURRENT SYMPTOMS PROMPTING THE REQUEST FOR TESTING?

❑ Anxiety Self-injurious Behavior
❑ Depression
❑ Withdrawn/poor social interaction
❑ Mood instability
❑ Psychosis/Hallucinations
❑ Bizarre Behavior
❑ Unprovoked agitation/aggression

❑ Eating disorder symptoms: ______________________
❑ Poor academic performance
❑ Behavior problems at home
❑ Behavior problems at school
❑ Inattention
❑ Hyperactivity

❑ Other __________________
____
____

What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information? How will testing affect the care and treatment in a meaningful way?

HISTORY

Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures in the past?

❑ Yes ❑ No Comments: ____________________

Does the patient have a family history of psychiatric disorders, behavior problems or substance use disorder?

❑ Yes ❑ No ❑ Uncertain Comments: ____________________

Is there any known or suspected history of physical or sexual abuse or neglect?

❑ Yes ❑ No ❑ Uncertain Comments: ____________________

If ADHD is a diagnostic rule out, please complete the following: Is the patient's presentation on intake consistent with ADHD?

❑ Yes ❑ No

Indicate the results of Conner's or similar ADHD rating scales, if given:

❑ Positive ❑ Negative ❑ Inconclusive ❑ N/A

If the patient is a child, please indicate the collateral information you have obtained from the school regarding cognitive/academic functioning (ie., teacher feedback, results of school standardized testing)? ____________________

____

____

Date of Diagnostic Interview: ____________________

Has the patient had a Psychiatric Evaluation? ❑ Yes ❑ No If yes, date? ____________________

Previous Psychological Testing? ❑ Yes ❑ No If yes, date? ____________________

Basic Focus and Results ____________________

____

Current Psychotropic Medications: ____________________

____

PLEASE LIST THE TESTS PLANNED TO ANSWER THE CLINICAL QUESION(S)

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

PLEASE INDICATE THE NUMBER OF UNITS REQUESTED TO COMPLETE TESTS:

____

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

____________________ Clinician Signature ____________ Date ____________________ Clinician Signature ____________ Date

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