FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME

Neuropsychological Testing Request ☐
Psychological Testing Request ☐

Please check one of the above. When complete, please fax to 1.855.396.5730
Please type or print clearly. Incomplete and illegible forms will delay processing.

1. Member Information

Member name _____ Eligibility ID # _____ SSN _____ DOB _____

Member address _____ City, State Zip _____ Phone _____

Who referred member for treatment? _____

2. Treating Provider Information

Name (include credentials) _____ NPI # _____ Phone _____

Address _____ City, State Zip _____ Fax _____

Group name/ID number _____ Contact name _____ Treating provider signature _____

3. Testing Requested: Neuropsychological: ___ 96118 ___ 96119 ___ 96120 **Psychological:** ___ 96101

4. Referral Reason and Functional Impairment _____

5. How will the anticipated results affect the member's treatment plan? _____

6. DSM-5 Diagnosis *(List all MH, SA, Medical)*

_____
_____
_____
_____
_____

7. Check Current Symptom(s) Prompting Request for Testing:

☐ Anxiety	☐ Withdrawal/social isolation
☐ Psychosis/hallucinations	☐ Unprovoked agitation/ aggression
☐ Mood instability	☐ Poor academic/employment performance
☐ Bizarre Behavior	☐ Eating Disorder Symptoms
☐ Inattention	☐ Behaviors impacting ADL's
☐ Hyperactivity	☐ Depression
☐ Other:	☐ Self-Injurious Behaviors

8. Current Medications

List with dosages or attach sheet _____

9. Check All Assessments to Date

☐ No assessment procedures performed to date
☐ Direct observation
☐ Assessment by mental health professional(s)
☐ Consultation with others
☐ Structured interview
☐ Interview with family/guardians
☐ Medical evaluation
☐ Review of records of previous treatment
☐ Clinical interview with patient
☐ Brief inventories or rating scales
☐ Consultation with patient's physician consultation
☐ Other, please list _____

10. Please answer the following. *Attach additional pages/records if necessary.*

Patient medical and psychiatric history: _____
Family medical and psychiatric history: _____
Describe any neurological events and/or neuro-developmental concerns: _____
History of psychological testing and results/findings: _____

11. Description of Testing Request

Test to be administered	Time required *(administration of test, scoring, interpretation and report preparation)*	Comments

Additional Information: _____