Empire Utilization Management Services
PO Box 2100
North Haven, 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):

Patient Name: _____ **Date of Birth:** _____

ID #: _____ **Subscriber Name:** _____

Provider Information:

Provider Requesting Testing: _____ Relationship to Patient: _____

Address: _____ Phone: _____

_____ Fax: _____

Provider to Administer Testing: _____

Address: _____ **Phone:** _____

_____ **Fax:** _____

Clinical Information:

Current Diagnosis (DSM IV) : **Axis I** _____ **Description** _____

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):

_____