BEHAVIORAL HEALTH SYSTEMS
Psychological Testing Authorization Request Form

Patient Information:

Name: _____ Insured's ID Number: _____

Provider Information:

Testing Provider's Name: _____ Phone: ( ) _____
Office Contact Person: _____ Fax: ( ) _____

Referral Source: _____

Prior Psychological Testing: Psychiatric Evaluation:

Date: _____/__/_____ No _____ Date: _____/__/_____ No _____

Have you completed a comprehensive Initial Assessment: Yes_____ No _____

DSM-IV-TR Diagnosis: Other diagnoses under consideration:
Axis I _____ _____
Axis II _____ _____

Specify all diagnostic and/or clinical questions to be answered:

_____
_____
_____
_____
_____

List specific tests proposed and time required for each:

Tests (do not use abbreviations)	Time
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Total Time Requested: _____

_____ _____
Physician Signature Date

Please fax completed form to BHS Clinical Services at (205) 879-1178