

## Psychological/Neuropsychological Testing Clinical Information Worksheet

Prior approval is required for psychological and neuropsychological testing. Completion of this worksheet is not mandatory, however this clinical information aides BCBSVT staff in completing these requests.

Date of Request:	Requested Date(s) of Service:
Patient Name:	Patient DOB:
Provider Administering Tests:	Provider's Credentials:

### Person or Agency Making the Initial Recommendation for Testing:

<input type="checkbox"/>	Psychiatrist	<input type="checkbox"/>	Psychotherapist	<input type="checkbox"/>	Testing Psychologist
<input type="checkbox"/>	Other Psychologist	<input type="checkbox"/>	Parent	<input type="checkbox"/>	Court/Probation
<input type="checkbox"/>	Teacher/School Staff ( <i>specify</i> ):				
<input type="checkbox"/>	PCP / Medical Specialist ( <i>specify</i> ):				
<input type="checkbox"/>	Other:				

- Are there any known contributing medical issues , including any known pregnancy/birth complications, brain injury, head trauma, lead poisoning etc.?
- What are the current symptoms and/or functional impairments the member is experiencing?
- Has the member has been referred for testing based upon a clinical evaluation from a Medical Professional?  Yes  No  
*\*If yes, please attach notes documenting this*
- Please list the specific question(s) to be addressed by testing:

5. How will results of testing facilitate treatment goals and/or provide information beyond that currently available? *Please be as specific as possible.*
6. If current testing is ADHD-related, indicate most recent results of Connors' or similar ADHD rating scales:
- Testing is not ADHD-related       Rating scales were positive       Negative
- Rating scales were inconclusive       Rating scales were not administered
7. Have medication effects been ruled out as a cause for symptoms in question?     Yes     No\*  
*\*If No, describe rationale for testing despite this information.*
8. Does the member have active alcohol or substance use that would be expected to affect the validity of testing?       Yes\*     No  
*\*If Yes, describe rationale for testing despite this information.*

**\*\*Please complete the following page\*\***

**Requested Testing** (if unknown by ordering provider, please leave blank):

Total number of hours requested: \_\_\_\_\_

Is testing primarily neuropsychological?  Yes  No

<b>Names and Type of Test:</b> <i>(Please print clearly and be precise when indicating the names or acronyms of the tests)</i>	<b>Time requested per test</b> <i>(include administration, scoring, interpretation and reporting):</i>

*\*Please attach additional sheet if needed.*

<b>CPT® Code Requested</b>	<b>Number of Units for Each Code</b>

Requesting Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_