



PSYCHOLOGICAL TESTING REQUEST FORM

ODS Behavioral Health
PO Box 5817
Portland, OR 97228-5817
Fax to: (503) 670-8349

All fields must be completed in order to expedite review

I. PATIENT INFORMATION

Member Name: _____
Member ID: _____ Date of Birth: _____

II. PROVIDER'S INFORMATION

Evaluator Requesting Authorization: _____	License: _____
Address: _____	
Phone: _____	Fax: _____
Provider Referring Member for Testing: _____	

III. CLINICAL INFORMATION – Current Diagnosis (DSM-IV-TR)

Axis I _____

R/O _____ R/O _____

Axis II _____

Axis III _____

Axis IV _____

Axis V Current GAF = _____ Highest Past year = _____

Presenting Problem and Reason for Referral:

Pertinent Psychiatric History:

Has the patient had any previous testing? If so, when and what were the results?

What are the specific referral question(s) that cannot be answered by diagnostic interview, review of records, or collateral information?

Tests Proposed:

<i>Name of Test</i>	<i>Purpose</i>	<i>Time Needed</i>
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Total Hours of Testing Requested (include write-up): _____

Signature of Requesting Psychologist: _____