



NEW AVENUES / MBHN:

Request for Psychological Testing

Employee Assistance Program · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980
Midwest Behavioral Health Network · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980

PSYCHOLOGICAL TESTING MUST BE PRE-AUTHORIZED: Psychological testing is a treatment adjunct: the sole purpose is to provide answers to specific questions about a client that will;
 1. Enhance and clarify the diagnosis of the client's problem(s), and 2. Support the treatment planning process.

I. Demographics: Request Date: _____
 Client Name: _____ Birth Date: _____
 Employer: _____ SSN/Case #: _____

II. Type of Initial Referral:
 MBHN Self Referral
 EAP Self Referral
 Employer Referral

III. Level of Care
 Out-Patient Treatment
 Partial Hospitalization
 Facility Name: _____
 In-Patient Treatment
 Facility Name: _____

III. DSM-IV Diagnosis:
 AXIS I: _____ Description: _____
 AXIS II: _____ Description: _____
 AXIS III: _____
 AXIS IV: _____
 AXIS V: (current GAF): _____ AXIS V: (past year GAF): _____

V. What current symptoms or conditions suggest the need for testing?

VI. Previous Testing:
 Has the client received any previous psychological testing? Yes No
 If yes, Please list dates of previous tests and type of testing used: _____

VII. Testing Proposed:
 What questions will be answered by psychological testing? _____

 How will this information enhance the diagnosis and treatment planning for this client? _____

<u>Type of Test Needed</u>	<u>Units Requested</u>	<u>Administered by</u>	<u>Type of Test Needed</u>	<u>Units Requested</u>	<u>Administered by</u>
① _____	_____	<input type="checkbox"/> Ph.D. <input type="checkbox"/> Technician <input type="checkbox"/> Computer	④ _____	_____	<input type="checkbox"/> Ph.D. <input type="checkbox"/> Technician <input type="checkbox"/> Computer
② _____	_____	<input type="checkbox"/> Ph.D. <input type="checkbox"/> Technician <input type="checkbox"/> Computer	⑤ _____	_____	<input type="checkbox"/> Ph.D. <input type="checkbox"/> Technician <input type="checkbox"/> Computer
③ _____	_____	<input type="checkbox"/> Ph.D. <input type="checkbox"/> Technician <input type="checkbox"/> Computer	⑥ _____	_____	<input type="checkbox"/> Ph.D. <input type="checkbox"/> Technician <input type="checkbox"/> Computer

Provider's Name (Print): _____

Provider's Signature: _____

Date Signed: _____