ACBHCS PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR)

Please fax this completed form along with the medical records documenting the clinical indications or medical necessity to ACCESS at 510-346-1083. Authorization for psychological testing will not be considered until all sections of this form are completed. Psychological testing should not be initiated until an authorization has been received. Please note that extended testing for ADHD is not authorized prior to a thorough evaluation with rating scales and a clear explanation as to why the initial evaluation was insufficient to answer ADHD referral question(s).

Client Name: DOB:

Client SS#: InSyst Client ID:

Client's Primary Language: Client's 2ND Language:

Caretaker's Primary Language: Caretaker's 2nd Language:

Client Address: Phone No(s):

Child Welfare Worker's Name: Contact No:

Psychological Testing Referral by: Phone No.:

Primary Therapist/Physician: Agency/Phone No:

Prior Psychological Testing? Y/N
Date tested: By Whom:
Testing Report Attached Y/N. If not, why not able to obtain?

Mental Health Assessment Attached? Y/N
If not, why not able to obtain?

What are the specific referral questions that cannot be determined by diagnostic interviews, mental health assessment, review of psychological/psychiatric records, or a second opinion?

What are the current symptoms and/or functional impairments related to testing question(s)?

How will the results of testing affect the Treatment Plan?

History of client.
[Summary of psychosocial and medical information (with examination dates) and past treatment; include any past psychological testing, date and results, medical, psychiatric and neurological exams. List current medical & psychotropic medications/dosage/start date.]

Are there other psychological or medical explanations for current behavior/symptoms (i.e. closed head injury, medications, poisoning, thyroid dysfunction, etc.)? Y/N. Explain:

Is client actively abusing any substances? History? Y/N. Explain:

If this request is URGENT please check here: [ ] Reason for Urgent Request:

Authorization Request (Check all that apply):

_____ 16 hrs. Psychological/Developmental Testing
_____ 5 hrs. Neuropsychological Testing
_____ 1.5 hrs. Additional Report for:
_____ 1.5 hrs. Additional Report for:
_____ 3 hrs. Additional for Travel time if Client is Homebound or unable to travel to the testing site.
_____ 3 hrs. Additional for Monolingual, Limited English Speaking or Limited English Proficiency Client.

Select One:

_____Assign to psychologist selected by Access
_____Name of psychologist suggested for testing:
Contact Phone:
Fax:
Date available to begin testing:
Is psychologist fluent in client/family's primary language?

Provider Signature (with credential): Date:

Clinical Supervising Psychologist Signature (if required): Date:

The Access Unit reserves the right to assign specific psychologists.
Fax this request to 510-346-1083. Please use HIPAA compliant faxing procedures.
<u>This client should be tested only after written authorization from Access</u>