BlueCross BlueShield of Vermont
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Psychological Testing Clinical Information Worksheet

A Prior Approval form must be used in addition to this worksheet. Please attach additional sheet if needed.

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:

	Psychiatrist		Psychotherapist		Testing Psychologist
	Other Psychologist		Parent		Court/Probation
	Teacher/School Staff *(specify)*:				
	PCP / Medical Specialist *(specify)*:				
	Other:				

Please list the specific question(s) to be addressed by psychological testing?

Why can’t this question be answered by a diagnostic interview, a medical and/or neurological consult, review of psychological / psychiatric records or second opinion?

What are the current symptoms and / or functional impairments related to testing questions?

How will results of psychological testing facilitate treatment goals and/or provide information beyond that currently available? *(please be specific)*

Medical issues *(including any known pregnancy/birth complications, brain injury, head trauma, lead poisoning)*:

Has the testing psychologist or other behavioral health professional completed a psychiatric diagnostic evaluation? *(Required)* □ Yes *(Date)* _______________ □ No

Has the patient had an evaluation by a psychiatrist? *(Required)* □ Yes *(Date)* _______________ □ No

Has the patient had previous psychological testing? □ Yes *(Date)* _______________ □ No

If yes, please explain why additional psychological testing is necessary:

*****If responding "Yes" to any of the above, please attach evaluation report(s).*****

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

All current Rx medications	Dose/frequency	Reason for taking medication

Have medication effects been ruled out as a cause for symptoms in question? □ Yes □ No*

**If no, describe rationale for testing despite this information:*

History of alcohol or other drug use: □ Yes* □ No

**If yes, please describe (including substance(s) used and date of last use:*

*****Please be sure to complete next page*****

Requested Testing:

Total number of hours requested: __________

Is testing primarily neuropsychological? □ Yes □ No

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

Please attach additional sheet if needed.

CPT® Code Requested	Number of Units for Each Code

****Prior to submitting for approval, did you attach all necessary evaluation reports? ☐ Yes**

Requesting Provider Signature: ________________________________ Date: __________________