coordinated care™

SUBMIT TO
Coordinated Care
Utilization Management Department
1145 Broadway, Suite 300
Tacoma, WA 98402
PHONE: 1.877.644.4613
FAX: 1.833.286.1086

OUTPATIENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

Please print clearly and fill out entire form even if the information is documented in attachments.
Incomplete or illegible forms will be returned. ***Required Fields**

*Date: _____

*Patient Information

*Name _____

*Date of Birth _____

*Patient Medicaid Number _____

*TIN # _____

*Referral Source _____

*Procedure Code _____

*Provider Information

*Provider Name _____

*Facility Name _____

*Provider NPI _____

*TIN# _____

*Phone _____

*Fax _____

*Number of Units requested _____

*Authorized Specific Contact Person _____

*ICD 10 Diagnosis Code(s):

*Are you a COE provider determining an Autism Diagnosis? ☐ Yes ☐ No

*Primary _____ R/O _____ R/O _____

Secondary _____

Additional _____ Additional _____

*Danger to self or others? ☐ Yes ☐ No (If yes please explain) _____

_____

Mental Health Status Exam (MSE) within Normal Limits ☐ Yes ☐ No (If yes please explain) _____

_____

*What are the current symptoms prompting the request for testing?

- ☐ Anxiety self
- ☐ Depression
- ☐ Widthdrawn/ poor social interactions
- ☐ Mood instability
- ☐ Psychosis/ Hallucinations
- ☐ Bizarre Behavioral
- ☐ Unprovoked aggression
- ☐ Eating disorder symptoms: _____
- ☐ Poor academic performance
- ☐ Behavior problems at home
- ☐ Behavior problems at school
- ☐ Inattention
- ☐ Hyperactivity
- ☐ Other: _____

***What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information?**

***How will testing affect the care and treatment in a meaningful way?**

***History**

History of Behavioral Health Services ☐ Yes ☐ No

If yes; was there any noticeable improvement? Please describe: _____

Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures in the past? ☐ Yes ☐ No

Comments: _____

Does the patient have a family history of psychiatric disorders, behavior problems or substance use disorder?
☐ Yes ☐ No ☐ Uncertain

Comments: _____

Is there any known or suspected history of physical or sexual abuse or neglect? ☐ Yes ☐ No ☐ Uncertain

Comments: _____

If the patient is a child, please indicate the collateral information you have obtained from the school regarding cognitive/academic functioning (i.e. teacher feedback, results of school standardized testing)? _____

_____

Date of Diagnostic Interview: _____

Has the patient had a Psychiatric Evaluation? ☐ Yes ☐ No If yes, date? _____

Assessments Activities Already Performed: (must have at least one)

☐ Mini-International Neuropsychiatric Interview for ☐ Adolescents ☐ Adults

☐ Anxiety Disorders Interview Scheduled for Children (ADIS)

☐ Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS)

☐ Children's Interview for Psychiatric Syndromes (Chips) Child and Parent (P-Chips) Version

☐ Schedule for Affective Disorders and Schizophrenia

☐ Structured Clinical Interview for DSM Disorders (SCID)

Validated Symptom or Rating Scale: (must have at least one)

What was completed: _____

(Examples: Beck Inventory, Dissociative Experiences Scale, Eating Disorder Scale, Mood Disorder Questionnaire, Trauma Life Events Questionnaire)

Test to be Administered:

- ☐ Minnesota Multiphasic Personality Inventory ☐ Adolescents ☐ Adults
- ☐ Millon Adolescent Clinical Inventory
- ☐ Personality Assessment Inventory
- ☐ Other

_____

_____

Collateral Information: (family member or others living with patient)

_____

_____

_____

Basic Focus and Results:

_____

_____

_____

Current Phychotropic Medications

_____

_____

_____

Please list the test planned to answer the clinical question:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Please attach initial evaluation/diagnostic interview and any previous psychological testing evaluations to support your request.