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Honolulu, Hawaii 96813
Phone: (808) 791-7505
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OUTPATIENT PSYCHOLOGICAL TESTING REQUEST

NAME OF PATIENT	MEMBER ID NUMBER	DATE OF BIRTH	
PROVIDER NAME	**PROVIDER PHONE**	**PROVIDER FAX**	
PROVIDER MAILING ADDRESS (if non-participating)	**CITY**	**STATE**	**ZIP CODE**

DSM-IV DIAGNOSIS (All Axis)		DESCRIPTION
Axis I (Code #)		
Axis I (Code #)		
Axis II: Code #)		
Axis III		
Axis IV		
Axis V	Current:	Highest in past year:

Previous Psych Testing (if any):	Test(s) Used	Date(s)	Results

CURRENT MEDICATIONS (if any)

NATURE OF REQUEST	DATE REQUESTED	TIME REQUESTED	PROPOSED START DATE	TOTAL NUMBER OF HOURS REQUESTED
☐ Neuropsych ☐ Psychological				

JUSTIFICATION

Psychological and/or neuropsychological testing is indicated when all of the four (4) following criteria have been met:

1. A diagnostic formulation or impression is deemed inadequate or incomplete;
2. Other medical, psychiatric & laboratory investigations are not considered, or have not been found to be adequate or appropriate;
3. Clinical experience suggests that the patient has underlying psychopathology which is not readily discernible or understood through standard clinical inquiry; and
4. A more effective and efficient treatment plan is likely to develop as a result of testing.

FOR HMAA USE ONLY	Auth. #	Date Authorized	Care Facilitator	Tests Authorized	Total #	Date	
						From	To