FirstChoice VIP CARE®
by Select Health of South Carolina

Neuropsychological Testing Request ☐
Psychological Testing Request ☐

Please check one of the above. When complete, fax to 1-844-211-0972.

Please type or print clearly. Incomplete and illegible forms will delay processing.

1. Member information

Member name:	Eligibility ID #:	SSN:	DOB:
Member address:	City, state, ZIP code:		Phone:
Who referred member for treatment?			

2. Treating provider information

Name (with credentials):	NPI #:	Phone:	
Address:	City, state, ZIP code:		Fax:
Group name or ID number:	Contact name:	Treating provider signature:	

3. Testing requested

☐ **Neuropsychological:** Insert service codes being requested:

☐ **Psychological:** Insert service codes being requested:

Referral reason and functional impairment:

How will the anticipated results affect the member's treatment plan?

4. DSM-5 diagnosis

List all mental health, substance use, and medical diagnoses:

5. Current symptoms prompting request for testing

☐ Anxiety ☐ Psychosis or hallucinations ☐ Mood instability ☐ Bizarre behavior ☐ Inattention	☐ Hyperactivity ☐ Withdrawal or social isolation ☐ Unprovoked agitation or aggression ☐ Self-injurious behaviors ☐ Eating disorder symptoms	☐ Behaviors impacting activities of daily living (ADLs) ☐ Depression ☐ Poor academic or employment performance ☐ Other: _____

6. Current medications

List with dosages or attach sheet:

7. Assessments to date

☐ No assessment procedures performed to date ☐ Direct observation ☐ Assessment by mental health professionals ☐ Consultation with others ☐ Structured interview ☐ Interview with family or guardians	☐ Medical evaluation ☐ Review of records of previous treatment ☐ Clinical interview with patient ☐ Brief inventories or rating scales ☐ Consultation with patient's provider ☐ Other (please list): _____

Original November 2021

Neuropsychological/Psychological Testing Request

Please answer the following. Attach additional pages and records if necessary.

Patient medical and psychiatric history: _____

Family medical and psychiatric history: _____

Describe any neurological events and/or neurodevelopmental concerns: _____

History of psychological testing and results or findings: _____

8. Description of testing request		
Test to be administered	**Time required** (administration of test, scoring, interpretation, and report preparation)	**Comments**

Additional information