

NEUROPSYCHOLOGICAL TESTING AUTHORIZATION REQUEST

Patient's Name: _____	SSN#: _____ - _____ - _____	DOB: ____ / ____ / ____
Provider's Name: _____	Group Name: _____	
Provider's Phone Number: (____) _____ - _____	Fax: (____) _____ - _____	

History of medical condition, trauma, or substance use that may have neuropsychological consequences to the patient: _____

Patient's cognitive symptoms/issues: _____

Patient's psychiatric symptoms/issues: _____

History of previous treatment for the above symptoms? _____

Will this testing all or in part be used for educational/vocational remediation? Yes No
If yes, please explain:

How will understanding the neuropsychological status of this patient affect the treatment plan? _____

What are the patients diagnostic rule outs/referral question? _____

Test Planned:	Date Requested:	Time Requested:
1.		
2.		
3.		
4.		
5.		
6.		

I verify that the information provided within this report is an accurate representation of the patient's status and that I am privileged to administer this procedure.

Clinician Name

Clinician Signature

Date

504 Lavaca, Suite 850 ♦ Austin, Texas 78701
800-947-0633
♦ 512.406.7215 (fax)

Date Received: _____ **Date Processed:** _____ Referral Source: _____