This is a fillable Word form. The shaded cells will expand as you type into them.

Out-of-Panel Psychological Evaluation* Request Form for WVCH Members

Send to BCN by confidential fax to 503-585-4989 or by secure email to authorizations@mvbcn.org

* Also called Psychological Testing or Psychological Assessment

A. Requesting & Delivering Provider Information	
Requesting provider name:	**Ph:**
Email:	**Fax:**
Requested delivering psychologist (if known)**:**	**Ph:**
Email:	**Fax:**

B. Member Information			
Member name:		**Member DOB:**	**Member ID:**
If member is under 18, include guardian information:			
Guardian name:			For members under 18 or in guardianship, guardians should be prepared to participate in testing as requested by delivering provider.
Ph:	**Email:**		
Is guardian aware of this request? Yes No			

C. Member's Treatment Team**	**Provider consulted & in agreement w/ request**
Medical PCP:	Yes No None
Primary MH provider:	Yes No None
Other provider:	Yes No None
** If any member of the treatment team is not in agreement with this Psychological Evaluation request, please briefly discuss in Section D.2 below the efforts at consultation and collaboration, and why there is not agreement amongst the parties.	

D. Clinical Information	
1. Is the primary or sole purpose of testing to assess a medical condition (e.g., Fetal Alcohol Syndrome, TBI, epilepsy)? For details, please refer to these resources in the "Providers" section of BCN's website at www.mvbcn.org: Page 24 of BCN's Provider Manual - "Psychological Testing" and BCN's "Mental Health Related Evaluation, Assessment, and Testing Terminology Guide".	Yes No

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2. What are the specific clinical question(s) testing will answer, and how will testing inform treatment?

Common questions are diagnostic clarification, needing substantiated Autism diagnosis, member not responding to treatment, and/or needing treatment recommendations. If asking for diagnostic clarification, please specify which diagnosis(es) you need ruled in or out.

3. What is(are) member's current mental health diagnosis(es)? Please use ICD-10 definition(s) and F code(s).

Definition	F Code	Definition	F Code
1.		2.	
3.		4.	

4. Has member had previous psychological/neuropsychological testing? Yes No Unknown

Please request and review records of previous testing prior to submitting this request to determine if referral question can be answered by previous testing. **If member has had previous testing, address below why additional testing is needed.** Previous testing should be submitted as collateral information for this request.

5. If member is not enrolled in MH treatment, give the reason(s) the referral question(s) cannot be answered by diagnostic interview, review of records, behavioral observation, or collateral information.

Please read before submitting this request:

- This form must be filled out completely. The answers must provide enough clinical information to justify the Psychological Evaluation request. The request may be denied if there is not enough information to make a decision.
- Clinical documentation needed for a Psychological Evaluation request includes: recent Mental Health Assessment recommending psychological testing with a clinical rationale; PCP chart notes that demonstrate medical causes have been ruled out as contributing to presentation, if appropriate; and previous psychological evaluation(s), if available.
- A request may be denied if the questions can be addressed by routine outpatient mental health services.

Questions? Call BCN at 503-361-2778