RESET

PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL ASSESSMENT SUPPLEMENTAL FORM

IDENTIFYING INFORMATION		
Dates of Service Requested: (Start)_____	(End)_____	
First Name:	Last Name:	MI:
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female Other:	
Policy Number:		
Health Plan:		
Date Form Submitted:	Preferred Language (if other than English):	
Servicing Clinician:	**Facility:**	
Phone Number:	TIN/NPI#:	
Name and Role of Referring Individual:		☐ Self Referred
Contact Person:	Best Time to Contact:	
Phone Number:	Fax:	
Email:		
Site Address:		
Requesting Clinician/Facility *(only if different than service provider)*:		
Phone Number:	TIN/NPI#:	
Contact Person:	Best Time to Contact:	
Phone Number:	Fax:	
Email:		

RELEVANT DIAGNOSTIC DATA	
Primary possible diagnosis which is the focus of this assessment:	
Possible comorbid or alternative diagnoses:	☐ None
List all other relevant medical/neurological or psychiatric conditions suspected or confirmed:	☐ None
Relevant results of imaging or other diagnostic procedures (provide dates for each):	☐ None

ASSESSMENT PLAN AND HISTORY

Psychological and Neuropsychological Test Evaluation Services		**Psychological and Neuropsychological Test Administration and Scoring**	
Please enter number of units requested		*Please enter number of units requested*	
Psychological Testing Evaluation Services, 1st hour	96130=	Test Admin by Professional, first 30 minutes	96136=
Additional hour (List Separately)	96131=	Additional 30 minutes (List separately)	96137=
Neuropsychological Testing Evaluation Service, 1st hour	96132=	Test Admin by Technician, first 30 minutes	96138=
Additional hour (List Separately)	96133=	Additional 30 minutes (List separately)	96139=
Automated Testing and Result	96146=	Neurobehavioral status exam, 1st hour	96116=
		Additional hour (List separately)	96121=

List Likely Tests:

What suspected or confirmed factors suggested that assessment may require more time relative to test standardization samples?

☐ Depressed mood
☐ Low frustration tolerance
☐ Vegetative symptom
☐ Grapho-motor deficits
☐ Other (please specify):
☐ Physical symptoms or conditions (such as):
☐ Suspected processing speed deficits
☐ Performance Anxiety
☐ Receptive communication difficulties

Why is this assessment necessary at this time?

☐ Contribute necessary clinical information for differential diagnosis including but not limited to assessment of the severity and pervasiveness of symptoms; and ruling out potential comorbidities.
☐ Results will help formulate or reformulate a comprehensive and optimally effective treatment plan.
☐ Assessment of treatment response or progress when the therapeutic response is significantly different than expected.
☐ Evaluation of a member's functional capability to participate in health care treatment
☐ Determine the clinical and functional significance of brain abnormality.
☐ Dangerousness assessment
☐ Assess mood and personality characteristics impact experience or perception of pain.
☐ Other (describe):

Has a standard clinical evaluation been completed in the past 12 months? ☐Y ☐N

If yes, when and by whom:

If no, explain why a standard clinical evaluation cannot answer the assessment questions:

Date of last known assessment of this type: ☐ No prior testing

If testing in past year, why are these services necessary now?

☐ Unexpected change in symptoms
☐ Evaluate response to treatment
☐ Assess function
☐ Previous assessment is likely invalid
☐ Other (please specify):

Are units requested for the primary purpose of differentiating between medical, psychiatric conditions, learning disorders and/or guiding health care services? ☐Y ☐N

Are the units requested for the primary purpose of determining special needs educational programs? ☐Y ☐N

Are the units requested to answer questions of law under a court order? ☐Y ☐N

Currently known symptoms and functional impairments of the patient that warrant this assessment:

RELEVANT MENTAL HEALTH/SUD HISTORY

Relevant Mental Health History: ☐ None

Is substance use disorder suspected? ☐Y ☐N | If yes, how many days of sobriety:

Are medication effects a likely and primary cause of the impairment being assessed? ☐Y ☐N

If yes, is this assessment necessary to evaluate the impact of medication on cognitive impairment and inform clinical planning accordingly? ☐Y ☐N

If no, explain why testing is necessary:

If the primary diagnosis is ADHD, indicate why the evaluation is not routine:

- ☐ Previous treatment(s) have failed and testing is required to reformulate the treatment plan
- ☐ A conclusive diagnosis was not determined by a standard examination
- ☐ And/or specific deficits related to or co-existing with ADHD need to be further evaluated
- ☐ Other (please specify):

Signature of requesting clinician: