DATE OF 1st CALL:

INITIALS FILLING OUT FORM:

34 W Main St., Suite D, Hamlet, NC 28345
Phone (910) 557-0044 – Fax (910) 716-9177
www.goodwinpsychologicalservices.com

Referral Form for Psychological Testing

Client Information

Name:	Date of Birth:	Race/Ethnicity:
Gender: ☐Male ☐Female	School & Grade:	
Services Requested: ☐ Psychological Testing		
CONTACT NUMBERS:	Message ok? ☐ Yes ☐ No	
ADDRESS:		

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	Type of setting: ☐ Home ☐ Group Home ☐ Foster Home ☐ Psychiatric hospital ☐ Other

Payment Information:

Type of Insurance: Medicaid ☐Sandhills Center ☐United Healthcare Com. ☐Carolina Complete ☐Healthy Blue If no insurance, household income:	☐United Healthcare ☐NC Medicare	☐ BCBS ☐	Humana Military (Tricare)	☐Other (please note, these are OON and self-pay)
Primary Insurance ID#	Phone #			
Secondary Insurance ID#	Phone #			

Insured Person (if not patient)

Name:	Date of Birth:		
Gender: ☐Male	☐Female		
Relationship to insured: ☐Self	☐Child	☐ Spouse	☐Other
CONTACT NUMBERS:			
ADDRESS:			

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name	Mailing Address
Phone# Email address:	Fax#
How did you hear about Goodwin Psychological Services?	

What is the clinical question to be answered by testing?

What is the reason this question cannot be answered by a diagnostic interview, medical/neurological consult, review of psychological/psychiatric records or second opinion?

What are the current symptoms and/or functional impairments related to testing question?
Describe the member's current presentation.

How would the results of testing affect the treatment plan? Be specific.

Has the member used any substances in the last 30 days?

☐**Yes** ☐**No**

If yes, describe:

Has the testing psychologist or other behavioral health professional completed an initial diagnostic evaluation
If yes, please fax records or have patient upload into the client portal once given access

☐**Yes –** Date of evaluation: ☐**No**

Has the patient been evaluated by a psychiatrist?

☐**Yes –** Date of evaluation: ☐**No**

Has there been previous psychological testing?

☐**Yes –** Date of evaluation: ☐**No**

Testing area of focus:
If yes, please fax report or have patient upload into the client portal once given access

Child/Adult Mental Health Information:

Current medication & dosage	Current DSM-IV Diagnosis

Prescribing Physician name & Phone					
Current Mental Health Symptoms:	**Unknown**	**Not Present**	**Mild**	**Moderate**	**Severe**
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

Office Use only:

Request date: **Testing start date:**

Tests to be administered/requested testing (to be completed by testing provider):

Technician attestation:

If technician CPT codes (96138 or 96139) are requested, the supervising psychologist must complete the following attestation.

By checking this box, I attest to the following:

1. The services billed under the technician CPT code(s) will be delivered by an individual with the appropriate training and experience to administer these tests.
2. The services will be delivered under my direct supervision.
3. The services will be provided in the office/facility where I render psychological services.
4. My employment and supervision of the technician complies with all applicable state laws and regulation, including those governing psychologists.
5. I am responsible for the equality and accuracy of the services provided by the technician.
6. I am responsible for the analysis and interpretation of the test results and final report.

Supervising psychologist: Date

CPT codes and descriptions For services rendered on or after Jan. 1, 2019	**Requested units**
96130 – Psychological testing evaluation services by physician or other QHP, including integration of patient data, interpretation of standardized testresults and clinical data, clinical decision-making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s); when performed, first hour	_____ unit (only 1 unit of 1 hour allowed)
96131 – Psychological testing evaluation services by physician or other QHP; each additional hour	_____ number of additional hours
96132 – Neuropsychological testing evaluation services by physician or other QHP, integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s); when performed, first hour	_____unit (only 1 unit of 1 hour allowed)
96133 – Neuropsychological testing evaluation services by physician or other QHP; each additional hour	_____ number of additional hours
96136 – Psychological or neuropsychological test administration and scoring by physician or other QHP; 2 or more tests, any method, first 30 minutes	_____unit (only 1 unit of 30 minutes allowed)
96137 – Psychological or neuropsychological test administration; 2 or more tests, any method, each additional 30 minutes	_____unit(s) additional units of 30 minutes each
96138 – Psychological or neuropsychological test administration and scoring by technician; 2 or more tests, any method, first 30 minutes	_____unit (only 1 unit of 30 minutes allowed)
96139 – Psychological or neuropsychological test administration and scoring by technician; 2 or more tests, any method, each additional 30 minutes	_____unit(s) additional units of 30 minutes each
96146 – Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	_____unit (only 1 unit of 1 hour allowed)
Total number of hours requested (count automated test administration as 1 hour):	_____total hours (use .5 to indicate half an hour [e.g., 5.5])

Testing provider information:
Tanya Goodwin, Psy.D., HSP-P
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Individual NPI: 1184052953
Group NPI: 1760934343
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