



PSYCHOLOGICAL TESTING REQUEST FORM

Patient Name _____ Date _____

DOB: _____ Age _____ Member ID _____

Insurance _____ Requesting Provider _____

Provider Phone _____ Provider Fax _____

Provider Office Address where Patient will be seen: _____

Diagnosis (List if Provisional or Rule Out)

AXIS I	
AXIS II	
AXIS III	

Current Medications	Other Clinicians Involved in Treatment

Reason for Psychological Testing/Information to be Gained

Test and Maximum Time Allowable		Test and Maximum Time Allowable	
MPPI-2/MPPI-A	1 hour	MCMI/MACI	1/2 hour
Rorschach	2 hours	WRAT III	1/2 hour
WAIS III	2 1/2 hours	Zung/BDI/CDI	1/2 hour
WMS III	2 1/2 hours	Report: 1/2 hour for ≤ 2 hours testing	
WISC III	2 hours	Report: 1 hour for ≥ 2 hours testing	

Other Tests Requested	3.
1.	4.
2.	5.

Approved by: _____ Date _____

*Mail completed form to: ATTN: Case Management
 Mesa Mental Health
 PO BOX 90607
 Albuquerque, NM 87199-0607
 Fax completed form to: (505) 816-6702*