COLLEGE HEALTH IPA

PSYCHOLOGICAL TESTING PLAN

Patient Name: **Date:** **DOB:**

Referring Provider:_______________ Phone:(____)_______________ FAX:(____)_______________

A. Reason for testing:

B. Describe how the treatment plan is going to be affected by the results of testing:

C. Current DSM-IV Diagnosis under evaluation:

Axis I

Axis II

Axis III

Axis IV ☐ Family ☐ Social ☐ Educational ☐ Occupational ☐ Housing ☐ Economic ☐ Health Care ☐ Legal ☐ Other Description/Severity:

Axis V Current GAF: Highest GAF in past year:

D. History of Patient (Include any past psych testing, date and results):

E. Describe the results of treatment to date and the reason testing is indicated at this time:

F. List tests that most appropriately describe the questions to be addressed:

Clinical Questions	Specific Test Planned	Hours Required
Organic/Neuro-Psycholgical Factors		
Disturbances in Reality Testing		
Degree of Affective/Behavioral Disturbance		
Other:		

Provider's Signature: _______________ Date: _______________

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