COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
INTENSIVE CARE DIVISION – CLINICAL OPERATIONS
MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION

# PSYCHOLOGICAL TESTING REQUEST (PTR)

Client Name: ____________________________________________ DOB: _________ Primary Language: ________

Client Address: ____________________________________ City/State/Zip: ___________________________________

Phone No(s): _____________________________________________________________________________________

Social Worker's Name: __________________________________ Contact No: ________________________________
(Form 5005 is **required** if under DCFS supervision. Please fax directly to the Psychological Testing Unit)

Psychological Testing Referred by: _________________________________ Phone No.: ________________________

Primary Therapist/Physician: ______________________________________ Agency: ___________________________

Address: _________________________________________ City/State/Zip: __________________________________

Phone: _______________________ Fax: _______________________ Email: ______________________________

Prior Psychological Testing: ☐ No ☐ Yes Date tested: ______________ By Whom: _______________________

Specific referral questions:
Test referral questions must relate to mental health treatment. Attach additional pages if necessary.

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How long has your client been in treatment with you:______________

Select One: ☐ psychologist selected by the Psychological Testing Unit

☐ Name of psychologist suggested for testing: _____________________________________________

Contact Phone: _____________________________________ Fax: _______________________

**Please note:** ➢ **Fax this request to 213-738-4412. Please use HIPPA compliant faxing procedures.**