

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.

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.

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