COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
INTENSIVE CARE DIVISION – CLINICAL OPERATIONS

PSYCHOLOGICAL TESTING REQUEST-RESPONSE (PTR-R)

Medi-Cal status must be verified prior to performing psychological testing.

Date: _____

Request for Testing of:
Client Name: _____ DMH ID#: _____ MEDS ID number: _____

Client Address: _____

Assigned Psychologist's Name: _____ Phone: _____

Fax: _____ Email: _____

I agree to:

1) Consult with beneficiary's therapist/DMH Case Manager prior to testing, and to provide documentation of the consultation in the psychological report;
2) Conduct a comprehensive psychological evaluation that includes: history, test behavior, mental status examination, along with individually administered measures of intelligence, achievement, neuropsychological screening, psychodiagnosis, and personality;
3) Provide a report to the referring source that integrates current test results and prior test results, as well as directly answering the referral questions which are specific and unique to this beneficiary;
4) Forward a copy of the test report to the Psychological Testing Authorization and Quality Assurance Section before a copy is given to the referring party.

Signature of Testing Psychologist: _____ Date: _____

DMH USE ONLY BELOW THIS LINE

Psychological Testing Referral Package

Request Pending

☐ **Testing request pending until the following conditions are met):**

- ☐ Receipt of Form 5005 ***directly*** from CSW with SCSW signature.
- ☐ Receipt of permission to test from conservator.
- ☐ Client must be examined by a medical specialist prior to psychological testing. Please inform this office when the exam has occurred.
- ☐ Other _____

Reviewer: _____ Date: _____

PTR – RESPONSE
DMH Fax: 213-738-4412