COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
HEALTH ACCESS AND INTEGRATION
CENTRAL AUTHORIZATION DIVISION

PSYCHOLOGICAL TESTING REQUEST (PTR)

Client Name: _____ DOB: _____ Primary Language: _____

Client Address: _____ City/State/Zip: _____

Phone No(s): _____

DCFS CSW'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 213-947-4992. Please use HIPAA compliant faxing procedures.**

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