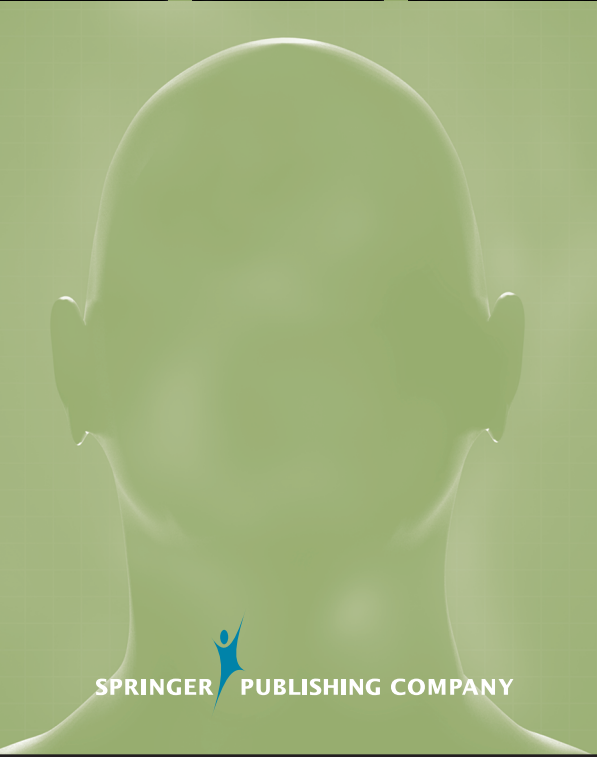
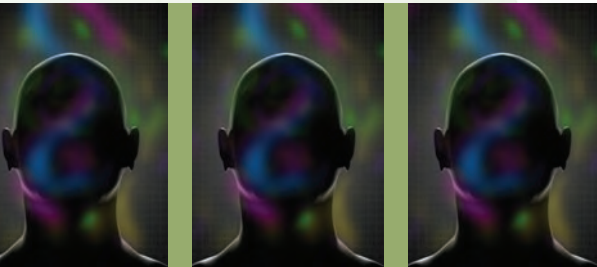


John M. Spores

Clinician's Guide to PSYCHOLOGICAL ASSESSMENT *and* TESTING

With Forms and Templates
for Effective Practice



CLINICIAN'S GUIDE TO PSYCHOLOGICAL ASSESSMENT AND TESTING

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WITH FORMS AND TEMPLATES FOR
EFFECTIVE PRACTICE

JOHN M. SPORES, PhD, JD

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*To Jesus Christ, Lord and Savior of me and
my loving family Billie, Andrew, and Demetra Spores,
along with our two loyal dogs Max and Moe Spores.*

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Psychological assessment and testing in mental health has changed significantly from the time I began practicing at a master's degree level in 1982. Although most insurance companies value psychological testing for purposes of accurate diagnosis, and consequently more efficacious treatment, they are simultaneously reluctant to approve more than three to five testing hours due to cost control. Additional criteria for test approval include the following: (a) documented presence of diagnostic ambiguity subsequent to diagnostic interview and clinical observations, (b) lack of response to previous intervention, and (c) demonstrated evidence of medical necessity. The latter renders contemporary psychological testing in mental health essentially focused on resolving differential diagnostic issues as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* (American Psychiatric Association, 2000), although supplementary referral questions may also be addressed (e.g., the nature and extent of neuropsychological impairment subsequent to traumatic brain injury).

This means that contemporary psychological testing must be sufficiently justified, brief, and well targeted. Tests that comprise the battery must measure clearly defined and validated constructs, including, for example, the various Axis I and II *DSM-IV-TR* diagnoses, intelligence, and adaptive behavior. The included tests must also be remarkably selective, in their most recently published editions, sufficiently standardized and age appropriate, rapidly scored and interpreted, and the essential results reduced to writing in the most effective and efficient manner.

Graduate training in clinical assessment and testing emphasizes the proper administration, scoring, and interpretation of the most frequently used individual cognitive and personality tests, with some training in data integration and report-writing. However, there is a paucity of coverage regarding critical issues necessary for effective testing practice within the mental health field, including, but not limited to, the following: (a) communication with referral sources as to appropriate testing referral questions, (b) judicious selection of tests as determined by diagnostic and referral questions and carefully gleaned diagnostic interview information, (c) type of information to include in the initial psychological assessment report so as to maximize the probability of insurance authorization for a reasonable number of testing hours, (d) determination of the order of test administration, and (e) organization of the final psychological evaluation report. The latter includes structuring the order and format of essential test results and associated interpretations, effectively presenting the final *DSM-IV-TR* diagnoses, answering supplementary referral questions, and deriving logically inferred and succinct treatment recommendations.

Based upon the completion of more than 2,500 psychological and neuropsychological evaluations which have involved formal standardized testing, including cases ranging in age from approximately 2 to 92 years, I have developed: (a) a standard process of assessment, testing, report-writing, and feedback to patients; and (b) a cohesive test inventory that effectively addresses most *DSM-IV-TR* diagnostic dilemmas and a broad range of related referral questions for the aforementioned age range. The former includes hard copy and electronic versions of referral and related forms, and initial psychological assessment

reports for child and adult cases, including critical areas of coverage for purposes of obtaining insurance approval of testing hours. The latter includes hard copy and electronic templates of results and interpretation tables for all tests included in the aforementioned inventory for purposes of rapid and efficient integration into the final psychological evaluation report.

My principal goal in writing this book is to provide psychologists with the practical tools needed for the effective and efficient practice of psychological assessment and testing within contemporary mental health. The corollary is to improve the quality and accuracy of psychodiagnosis, and to adequately address associated referral questions, for the ultimate purpose of more effectively guiding treatment intervention and reducing human suffering.

This book is primarily written for currently practicing clinical and counseling psychologists with a desire to practice assessment and testing either full- or part-time within the mental health field. It is also appropriate for graduate students who are in the advanced stages of training within these specialty areas. The principles and information presented in this book, however, may be generalized to other areas of assessment and testing practice (e.g., school psychology).

REFERENCE

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text rev.)*. Washington, DC: Author.

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THE NECESSITY OF STANDARDIZED TESTING FOR ACCURATE ASSESSMENT AND DIAGNOSIS

The *clinical method* of psychological assessment typically employs a semi-structured interview to gather detailed information regarding a patient's presenting symptoms, current mental status, and developmental history. The clinician relies on experience and expert judgment in arriving at diagnostic impressions and treatment recommendations. In the field of mental health, psychiatrists, clinical social workers, psychiatric nurse practitioners, master's-level mental health clinicians, and many doctoral-level psychologists who do not utilize standardized testing all rely primarily on the clinical method.

However, the accuracy and precision of the clinical method is deleteriously affected by numerous factors. Some of these include the clinician's reliance on base rates (e.g., when in doubt diagnose Schizophrenia or Bipolar Disorder on an inpatient unit or Borderline Personality in an outpatient setting), overestimating the accuracy of clinical judgment, being vulnerable to the *hypothesis confirmation bias* in which only that information that corroborates the suspected diagnosis is gathered (Meehl, 1954; Miller, McIntire, & Lovler, 2011), and significant symptom overlap among the various diagnostic categories of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* (see e.g., Barlow & Durand, 2012). Response bias on the part of respondents (e.g., acquiescence) and lack of introspection (e.g., see Larsen & Buss, 2010), also contribute to imprecision. Using testing parlance, these factors potentially contribute to a considerable degree of error variance in psychodiagnosis.

Regarding *DSM-IV-TR* diagnoses, a major epidemiological survey indicated that 46.4 % of Americans meet the criteria for a *DSM-IV-TR* disorder at some point in their lifetime (Kessler, Berglund, Demler, Jin, & Walters, 2005). Furthermore, 27.7 % of these manifest comorbidity (Kessler, Berglund, Demler, Jin, & Walters, 2005). The presence of comorbidity and remarkable symptom overlap among the *DSM-IV-TR* diagnostic categories renders accurate diagnosis a daunting challenge when relying solely on the clinical method (Krueger & Markon, 2006).

In particular, many disorders may be masked and remain undiagnosed when employing the clinical method. For example, a child diagnosed with Dysthymic Disorder, Early Onset who is manifesting chronic impairments in attention and concentration, may have comorbid Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type (ADHD-I). Using another example, an adult may have an Axis II Borderline Personality Disorder that is obscured by the more apparent mood cycling of an Axis I Bipolar I Disorder, Mixed Episode.

Moving to a related issue, it is remarkably difficult to discriminate precisely between comparable *DSM-IV-TR* diagnoses using the clinical method, which of course would significantly and negatively impact treatment outcome. Anecdotal evidence of this is reflected within the seemingly innumerable referral questions I have received from my

mental health clinical colleagues. Some examples include differentiating the following: (a) Bipolar I Disorder with Psychosis versus Schizophrenia; (b) Cyclothymic Disorder versus Borderline Personality Disorder; (c) Major Depressive Disorder versus Mood Disorder Due to Traumatic Brain Injury; and (d) Major Depressive Disorder with irritability versus Bipolar I Disorder with irritability.

Of final note, the median age of onset for *DSM-IV-TR* disorders is 14 years, with the majority of psychological disorders first manifesting in adolescence and young adulthood (Kessler, Berglund, Demler, Jin, & Walters, 2005). Most experienced clinicians will testify to the observation that many psychological symptoms are generally difficult for people to describe accurately within the context of a clinical interview. After all, many symptoms represent abstractions (i.e., psychological constructs) that must be logically inferred from historical behavior and subjective experience. It is thus reasonable to conclude that such difficulty would be magnified for younger patients including both children and adolescents. Taken together, psychological disorders are common, likely to be comorbid, appear relatively early in life, and are remarkably difficult to accurately diagnose by the exclusive use of the clinical method.

In contrast, the use of standardized psychological testing or the *statistical method* has proven significantly superior in terms of providing reliable and valid diagnoses (Dawes & Corrigan, 1974; Goldberg, 1970; Meehl, 1954; Wiggins, 1973). Furthermore, some diagnoses by definition necessitate standardized testing, including Mental Retardation and Learning Disorders. Similarly, many legitimate referral questions are impossible to address without standardized testing, including for example, identifying the nature and extent of brain damage subsequent to traumatic brain injury (TBI), and the extent of neuropsychological decline in a case of progressive Dementia.

Standardized testing also contends more effectively with issues of response bias on the part of patients and pertinent observers (e.g., parent ratings, self-report ratings). This includes measuring the degree of situational defensiveness, symptom exaggeration or malingering, and inconsistency in responding. Finally, the dimensional nature of psychological disorders is being increasingly recognized (e.g., see Kearney & Trull, 2012). In particular, standardized psychological testing is capable of measuring the degree or severity of *DSM-IV-TR* disorders more precisely than the clinical method. For example, more precise feedback can be afforded to parents regarding cases of mild or high functioning Autistic Disorder, or subclinical levels of Depressive Disorder (i.e., Depressive Disorder Not Otherwise Specified [NOS] or Minor Depressive Disorder).

In practice, the clinical method versus statistical method dichotomy is, to a recognizable extent, artificial (Sawyer, 1966). Diagnoses are arrived at most accurately under the following conditions: (a) the diagnostic interview information gleaned via the clinical method is initially employed to determine a well-targeted and efficient test battery; (b) the ensuing statistical method is employed for objective analysis of reliable and valid trends within the test data; and (c) any alternative interpretations noted within the test data are effectively resolved by reference to the aforementioned diagnostic interview information that provides meaningful diagnostic context (Sawyer, 1966).

Thus, the thesis of this book is that standardized psychological testing or the statistical method, supplemented by the clinical interview method, is requisite for arriving at the most reliable and valid *DSM-IV-TR* diagnoses, for effectively addressing related referral questions, and ultimately for effective treatment planning and intervention. Insurance companies recognize this as evidenced by their relatively consistent approval of a *circumscribed* number of testing hours, which is the product of an effective clinical interview used to justify the requested testing. Such companies reason that the cost of such targeted testing will be offset by more brief and effective treatment.

In my experience, insurance companies will most frequently approve between three and five testing hours, assuming the following have been demonstrated: (a) the presence of diagnostic ambiguity subsequent to clinical interview and observations; (b) the presence of *medical necessity* (i.e., differential *DSM-IV-TR* diagnosis); and, finally, (c) the documented lack of treatment progress (i.e., for cases in which treatment is already in progress). The second criterion, medical necessity, is based upon the medical model. It fundamentally includes the need for accurate *DSM-IV-TR* diagnoses, which will ultimately lead to one or more of the following: (a) symptom alleviation; (b) improvement in overall functioning; (c) prevention of deterioration; and/or (d) restoration of an expected level of development in children (Essential Learning, 2011). Taken together, this pragmatically means that psychological testing must be medically justified, targeted, and exceptionally efficient in terms of test administration, scoring, interpretation, and report writing.

REASONS MENTAL HEALTH PRACTITIONERS DO NOT UTILIZE STANDARDIZED PSYCHOLOGICAL TESTING

Perhaps the most frequent reason mental health clinicians do not employ standardized testing is that they lack such training. Psychiatrists, clinical social workers, and nurse practitioners are simply not trained in psychometrics and standardized testing. Licensed mental health clinicians (LMHC) with master's-level training in clinical or counseling psychology are in most cases precluded by third-party payors from providing standardized testing. Therefore, all of these mental health clinicians employ the clinical method of gathering information, conceptualizing a case in terms of one or more theories of psychopathology (e.g., biological, psychodynamic, cognitive-behavioral, family systems, eclectic), arriving at *DSM-IV-TR* diagnoses using clinical experience and expertise, and providing treatment accordingly.

On the other hand, many practicing clinical and counseling psychologists who are adequately trained in the statistical method provide little or no testing services. Instead, they prefer the clinical method for assessment and treatment. I believe there are several unfortunate yet compelling reasons for this eventuality.

First, graduate training in psychological assessment and testing does not adequately address issues of efficiency. Instead, students are typically trained to administer, score, interpret, and integrate all aspects of various common individual tests, including detailed and comprehensive analyses of examinees' strengths and weaknesses. I believe there is an insufficient amount of training that addresses the process of selecting an efficient test battery contingent on well-specified diagnostic issues, and in determining which test scores are most critical to report and interpret in a particular case. Furthermore, there does not exist a standard format or uniform style for writing psychological evaluation reports comparable to that of journal articles in psychology (see e.g., American Psychological Association, 2010). Reports tend to include ponderous and protracted narrative interpretations that are unnecessarily redundant, tend not to refer directly to standardized scores, are excessively tentative (e.g., "... which may suggest the possibility of or a potential for depression"), are consequently diagnostically ambiguous and obscure, and most pertinently, require excessive time.

Second, psychologists continue to practice standardized testing consistent with their graduate training. Insufficient training in brief and targeted testing contributes to the following: (a) selecting an excessive, overly inclusive, and redundant test battery and (b) requesting an excessive number of testing hours (e.g., 8 or 10 hours for a single case). Insurance companies are correctly cynical of such requests and may even perceive them as an abuse of the mental health care system (i.e., as a means of artificially enhancing billable

hours). This increases the likelihood of either an outright denial of testing, or the approval of significantly reduced testing hours (e.g., 1 or 2 hours). This also has a deleterious effect on testing approval for future cases. Thus, psychologists must choose between providing significantly more service hours versus hours reimbursed, or simply not completing the planned test battery. Neither alternative is palatable or reinforcing and a consequential resort to the clinical method is the corollary.

Compounding matters is the paucity of available training resources in psychological assessment and testing that address practical issues of efficiency. The majority of professional books and continuing education seminars are clinical-method oriented and treatment focused for various disorders, symptoms, and problem behaviors. Those that do address testing emphasize the proper administration, scoring, and interpretation of individual tests (see e.g., McCann, 1999).

PURPOSES, INTENDED AUDIENCE, AND ORGANIZATION OF THIS BOOK

This book is essentially a clinical guide in psychological assessment and efficient standardized testing in the field of mental health for purposes of (a) making the most reliable and valid *DSM-IV-TR* differential diagnoses, (b) effectively addressing related and proper referral questions, and (c) making pertinent and succinct treatment recommendations. This book is intended for practicing clinical and counseling psychologists who possess a desire to provide full- or part-time testing services. It is also directly applicable to advanced graduate students in these specialty areas as a supplement to their training in administering, scoring, interpreting, and reporting the results of individual tests. Finally, portions of the book (e.g., the process of testing, organization of the initial and final reports) may be of assistance to school psychologists who conduct testing within the educational system, and psychologists who administer standardized tests in industrial and organizational settings. I assume that the reader is sufficiently trained in diagnostic interviewing, psychometrics, and administering and scoring the various standardized tests presented and discussed in this book.

Section I comprises the first three chapters and is devoted to discussing the *process* of assessment and standardized testing from initiation to completion. More specifically, Chapter 1 outlines this process and provides a step-by-step flowchart. Chapter 2 describes the referral for testing process and completion of the initial psychological assessment report. It is supplemented by various forms and report templates. Chapter 3 describes test administration, scoring, simultaneous interpretation and report writing, and communication of the results. Modifications to the initial report are outlined and discussed, with an emphasis on the manner in which the scoring and interpretation tables for all tests presented throughout Section II of the book are to be incorporated into the final report. The espoused strategy is to maximize the scientific presentation of standardized test scores and their diagnostic meaning, while minimizing report writing time. It also provides a uniform system for composing the final report.

Section II discusses all of the standardized tests covered in this book. Each individual chapter covers a separate classification of tests and provides the following: (a) definitions of pertinent psychological constructs and their measurement; (b) diagnostic reasons for inclusion within a test battery; (c) administration, scoring, and interpretation strategies to maximize the efficiency and accuracy of diagnosis and addressing referral questions; and (d) tabular templates for presenting scores and their interpretations within the final report.

The classification of tests by chapter includes the following: Intelligence Tests (Chapter 4); Achievement Tests (Chapter 5); Neuropsychological Tests (Chapter 6); Symptom Rating Scales (Chapter 7); Self-Report Clinical and Personality Inventories (Chapter 8); Personality Tests (Chapter 9); and Adaptive Behavior Tests (Chapter 10). Note that

this taxonomy is based upon an integration of test type and format. Tests comprising my selected inventory were intentionally chosen for purposes of maximizing efficiency and minimizing costs, while addressing the broadest range of *DSM-IV-TR* diagnostic issues and frequently related referral questions.

Section III presents a sampling of cases classified by chronological age including children (Chapter 11), adolescents (Chapter 12), and adults (Chapter 13). These cases are discussed from the point of referral to the completion of the final report. Their purpose is to demonstrate the manner in which this assessment and testing system is intended to be applied in actual practice. A concluding Chapter 14 covers a special forensic report template and case example for conducting competence to stand trial criminal examinations. I believe that standardized psychological testing is of unique assistance to courts in resolving this legal issue. In particular, such testing is capable of presenting critical scientific data in these cases with greater precision as compared to psychiatric examinations that are based largely upon the clinical method.

Lastly, all of the forms, report templates, and test results and interpretation templates presented throughout this book in hard copy are available in modifiable electronic form on the Springer Publishing Company website at www.springerpub.com/spores. However, a formatting note is in order here. While the hard copy and electronic versions are identical in substance, there exist some page formatting differences. First, you will note some differences in font, indents, headers, and punctuation. Second, and more apparent, the electronic test results and interpretation tables include horizontal and vertical lines in order to clearly demarcate the row indices, scales, subscales, and variables from the column test scores and summary score and variable descriptions. The latter were inserted because the electronic versions are intended to be practice-oriented and more easily read by practitioners and laypersons who are not accustomed to reading and interpreting large data sets. I believe these internal lines, while not being strictly APA style format (American Psychological Association, 2010), are more reader-friendly to the majority of individuals who will ultimately read the testing reports. Of course, testing psychologists using these electronic forms may simply delete these internal lines at their discretion.

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SECTION I. THE PROCESS OF PSYCHOLOGICAL ASSESSMENT AND STANDARDIZED TESTING

Overview of the Assessment and Testing Process

1

THE TESTING PROCESS ANALOGOUS TO SCIENTIFIC RESEARCH IN PSYCHOLOGY

The testing process may be efficaciously analogized to steps followed in conducting scientific research in psychology. The latter is initiated by developing a testable research question or questions, and ends with communication of the results by oral presentation and/or formal written report (see e.g., Graziano & Raulin, 2010). Comparably, the testing process begins with a testable referral question or questions and is completed upon communicating the results in written, and frequently, oral formats. Figure 1.1 presents a flowchart of the major sequential steps in the psychological assessment and testing process. Each step comprises specific actions required, along with the pertinent forms and templates I have prepared. These are enumerated vis-à-vis each step in Figure 1.1 and are further introduced below.

OUTLINE OF THE PSYCHOLOGICAL ASSESSMENT AND TESTING PROCESS

Referral for Testing

The initial referral inaugurates the testing process. Referral sources can be classified as either external to your practice or agency (e.g., pediatrician, school, family member, self) or internal in the event you work within a group practice. In the latter case, the referral source is most probably a mental health clinician and colleague who does not provide psychological testing services (see the Introduction). Essential information in the initial referral step includes (a) clearly specified and appropriate diagnostic and related referral questions and (b) tenable reasons as to why testing is necessitated. I have prepared a succinct single-page referral form for this purpose (see Chapter 2).

Initial Psychological Assessment Report

The primary objective of the ensuing step is to complete an initial psychological assessment report by means of a clinical interview, including mental status examination and behavioral observations. Thus, the clinical method is employed to narrow the differential diagnostic focus, guided by the referral source's diagnostic and referral question(s). This facilitates the selection of a well-targeted test battery and the requesting of a circumscribed number of testing hours for maximum efficiency and effectiveness. I have prepared child and adult templates of the initial report (see Chapter 2) such that it may be completed during the interview process. These templates provide a format for semistructured interviewing and ensure that critical information will be gleaned and documented.

I have prepared a single-page test listing form that enumerates the names, abbreviations, and age ranges (by years:months) of each test in my recommended inventory (see Chapter 2). The tests are catalogued by either psychological construct or test format,

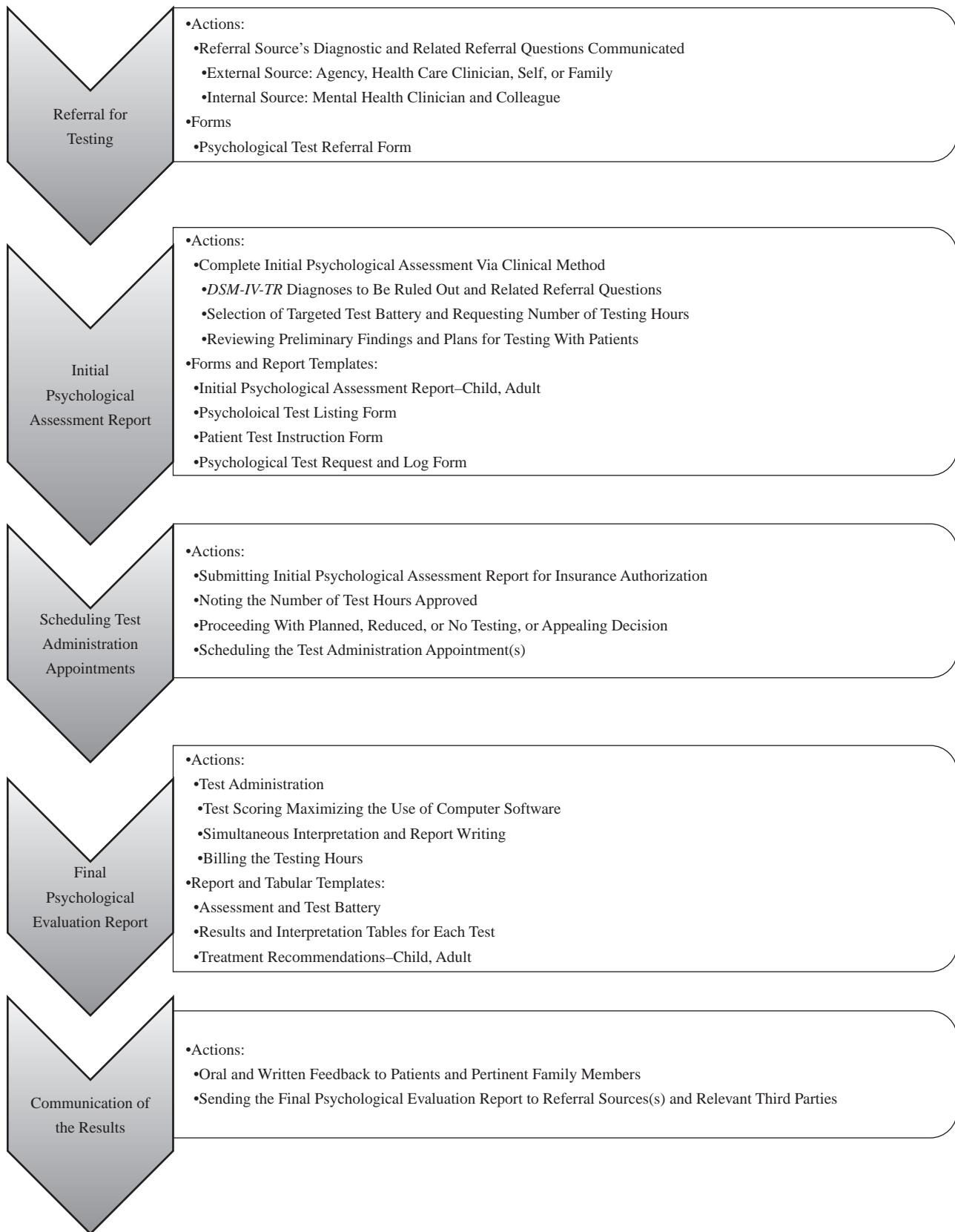


FIGURE 1.1 ■ FLOWCHART OF THE ASSESSMENT AND TESTING PROCESS

selected by whichever identifies them most readily. In addition, patients and pertinent family members should be afforded specific written test instructions such that they remain adequately informed throughout the remaining steps in the process. I have prepared a test instruction form for this purpose (see Chapter 2). Finally, I have prepared a form that is designed to assist the testing psychologist in tracking case progress (see Chapter 2).

Scheduling Test Administration Appointments

The logical next step is obtaining insurance authorization for the requested hours for purposes of scheduling test administration appointments. This is facilitated by immediately submitting the completed initial report. Assuming the request has not exceeded a range of 3 to 5 hours, with the exception of relatively more thorough neuropsychological test batteries (see Chapter 6), third-party payors will routinely approve all or the majority of these hours. In this event, proceeding with the test battery as planned is viable.

Approval of only 1 or 2 hours precipitates more complicated decision making, including proceeding as planned, reducing the test battery, not proceeding with testing, or appealing the decision. Finally, the number and duration of test administration appointments must be scheduled. If proceeding with the planned test battery, this information will already have been determined and communicated to the patient and pertinent family members. Simply scheduling these appointments is all that is required.

Final Psychological Evaluation Report

This step is analogous to running a psychological experiment as designed, ensued by statistical analyses of the results, and finally preparing the manuscript for publication (see e.g., Graziano & Raulin, 2010). Again, with the exception of administering a more in-depth neuropsychological test battery (see Chapter 6), test administration can usually be completed within a single 2-hour session. To maximize efficiency and reduce error variability due to inadvertent mistakes in manual scoring, use of computer-assisted scoring software is essential.

The celerity of the testing process is further enhanced by a method I have designed using simultaneous test interpretation and report writing. First, minor modifications to the initial report are made, including a new final report title, along with the insertion of a template listing the assessment procedures and tests comprising the battery with affixed parenthetical dates of completion (see Chapter 3). One such template is prepared for child cases and one for adult cases.

The body of the final report includes all of the test scores and their succinct interpretations. To complete this most vital section, I have prepared separate tabular templates for each test in my recommended inventory. In general, they include the following components: (a) an initial column listing the most essential indices, scales, subscales, and variables for a test; (b) an ensuing sequence of columns for standard scores; (c) a results column; and (d) a final column defining the measured psychological construct or cluster of symptoms. The majority of tables include pertinent tabular notes identifying standard score means, standard deviations, base rates, and necessary idiosyncratic information for particular variables. The tables are largely accordant with American Psychological Association manuscript style (American Psychological Association, 2010), and are presented and discussed in detail in Section II. Interpretive summaries may be composed by the psychologist and placed strategically between tables to maximize efficiency and minimize writing time.

Finally, I have prepared two templates that include a list of the most frequently applied treatment recommendations for child and adult cases (see Chapter 3). This section is inserted at the end of the final report.

Billing the test hours concludes this penultimate step. Test scoring, interpretation, and report writing should ideally all occur immediately subsequent to the final test administration session. As indicated prior, in most cases only one test administration session will be needed. This permits the billing of all utilized testing hours on this single date of face-to-face service. As an additional advantage, the case data will be fresh in the testing psychologist's memory and thus readily available. In consequence, less time will be needed for reviewing pertinent information.

Communication of the Results

Scheduling a test feedback appointment with the patient and pertinent family members is advisable, although not mandatory. This permits a thorough presentation of the results within a therapeutic context, which is facilitated by immediate reference to the final written report. A copy of the final report should be released to the referral source(s) once it is completed to expedite treatment intervention. Any release form used for this purpose should be HIPAA compliant (Health Insurance Portability and Accountability Act of 1996, 2000; Missouri Bar, 2006). The testing case may be considered complete once communication has been achieved and noted on the case progress form.

SUMMARY

Chapter 1 presented an overview of the psychological testing process from initiation to conclusion. It was intended as a prelude to Chapters 2 and 3, which together explicate the aforementioned steps in significantly more detail, including direct references to the particular forms and report templates alluded to here. Chapter 2 covers the first three steps, from the initial referral to the scheduling of testing appointment(s). Chapter 3 covers test administration through communication of the results.

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Referral for Testing, Initial Psychological Assessment Report, and Scheduling Test Administration Appointments

This chapter covers in detail the first three steps outlined in Figure 1.1, including the requisite steps in completing the initial report, and scheduling the test administration appointments. The process begins with properly managing the referral for testing.

REFERRAL FOR TESTING

Assuming you work within a group practice, referral sources may be classified as either external or internal. Common external referral sources include parents, educational institutions and staff, family physicians, pediatricians, neurologists, welfare departments, family services departments, and mental health clinicians in the community who do not provide assessment and testing services.

Internal referral sources largely include mental health clinicians who do not provide psychological testing, including psychiatrists (MD, DO), licensed clinical social workers (MSW, LCSW), nontesting psychologists (PhD, PsyD), licensed mental health clinicians (MA, LMHC), and nurse practitioners (RN). Of course, testing psychologists in individual practice rely exclusively on external referral sources.

In this incipient stage of the testing process, the essential goal is to unequivocally define the referral source's diagnostic and related referral questions. This information focuses and guides the completion of the initial report. Furthermore, the diagnostic and related referral questions must be capable of being empirically addressed by psychological testing.

I have prepared a document titled "Psychological Test Referral Form" (Form 2.1), which facilitates this process. I advise that you review this form with all potential referral sources such that they are completed fully and properly. They can be delivered to you through the patient or pertinent family members, via fax, or U.S. mail. Next, I review the main elements of this form.

Psychological Test Referral Form

This form is designed to be a succinct guide for referral sources to organize their diagnostic questions regarding a case and to avert improper referrals. I assume that all health practitioners have limited time such that a protracted form would discourage referrals. Therefore, this form attempts to achieve a viable balance between obtaining essential referral information and minimizing time to complete the form.

The first portion of the form is devoted to obtaining necessary patient and referral source information. Date of birth is essential to classify the case as child (younger than 18 years) or adult (18 years and older). The referring clinician information is needed for communication of the results, including having a record of that office's case file number for cross-referencing purposes (e.g., citation in a cover letter accompanying the final report).

The middle section presents key selections within a structured checklist format. They permit referring clinicians to quickly indicate (a) whether general psychological testing

or more specialized neuropsychological testing is being requested and (b) pertinent reasons for the testing referral. The latter options contain key words and phrases that third-party payors generally consider as acceptable and justifiable for purposes of authorizing test hours. As will become apparent, I have incorporated this same language into the initial report templates for child and adult cases.

The date of the initial behavioral health evaluation (billing code 90801) is primarily needed for internal referrals from mental health clinicians. Many insurance companies will limit the number of initial behavioral health evaluations completed within the same agency or practice to one per annum. The rationale is that the referral for testing is a continuation of the same treatment plan. Thus, in instances of an internal referral, if an initial behavioral health evaluation was indeed completed within a year of the initial psychological assessment session, it should be billed as an individual session (billing code 90806) and considered a continuation of the same treatment plan within the same group practice or agency. This evokes a service coding issue that is in need of further explication.

It is vital that the testing psychologist's service activities remain accordant with their billing codes. It is a well-established precept that the processes of assessment and treatment intervention are inextricably intertwined (see e.g., Corey, 2013; Spiegler & Guevremont, 2010). For instance, the interventions of empathy, and reflection of feeling and content, are frequently employed during an assessment so as to begin the establishment of trust and rapport necessary for both accurate psychodiagnosis and initiating the process of positive behavior change (see e.g., Evans, Hearn, Uhlemann, & Ivey, 2008). Therefore, when using the individual session billing code 90806 to initiate the diagnostic psychological testing process, it is critical to place sufficient documentation of the interventions employed as a continuation of that patient's treatment within the mental health progress note for that session. Some examples include, but are certainly not limited to, the following: (a) *processed issues of concern*, (b) *provided empathy and support*, (c) *employed reframing of negative cognitions*, (d) *provided psychoeducation*, and (e) *provided redirection*. These are all bona fide interventions that also facilitate the assessment process. Diligent and adequately detailed documentation of such interventions along with the patient's responses within the progress note associated with this billing code accomplishes the following: (a) it establishes reasonable agreement between the actual mental health services provided and the 90806 individual billing code and (b) it maximizes the likelihood of reimbursement by third-party payors.

Occasionally, however, some insurance companies will authorize a second initial behavioral health evaluation within the same practice and year, and thus the effort can still be made for such authorization. External referrals do not present such issues, as the initial psychological assessment would be the first session for that autonomous practice or agency and thus properly coded and billed as 90801.

The two subsequent sections of the referral form are in fill-in format. They ask for the referring clinician's current diagnostic impressions or working diagnoses, ensued by diagnoses that the clinician suspects and for which testing is desired (i.e., diagnoses needed to be ruled out). The open-ended format allows flexibility and may be stated concisely or with some elaboration.

A cautionary note immediately follows. It admonishes referring clinicians of testing requests which are routinely denied by third-party payors regarding mental health services, including (a) educational testing for Learning Disorders (see Chapters 4 and 5), (b) vocational testing within the context of career counseling, and (c) psychological testing that is ordered by a court of law (see Chapter 14). The general rationale for denial of these testing requests is lack of *medical necessity* (see the Introduction for a working definition). Regarding the former, testing for Learning Disorders is typically considered to be within the purview of the educational system and to be conducted by school psychologists.

The form ends with an optional open-ended fill-in section permitting the addition of any related referral questions to be addressed by testing. These include, but are not limited to, the following: (a) measurement of a patient's memory abilities, (b) measurement of intellectual functioning, (c) estimating risk for future violence or suicide, and (d) measuring response to treatment intervention in terms of symptom remission (e.g., symptoms of Attention-Deficit/Hyperactivity Disorder [ADHD]).

INITIAL PSYCHOLOGICAL ASSESSMENT REPORT

Information on the "Psychological Test Referral Form" will effectively guide the initial clinical interview and should be referred to during the assessment process.¹ The goal is to complete an initial report that does the following: (a) states provisional diagnoses, (b) confirms those diagnoses to be ruled out by standardized testing, (c) phrases any related referral questions in measurable terms, and (d) requests the most efficacious test battery which will answer the diagnostic and referral questions using the minimum number of testing hours.

To facilitate the process, I have prepared separate initial report templates for child and adult cases, respectively, identified as "Initial Psychological Assessment Report—Child" (Form 2.2) and "Initial Psychological Assessment Report—Adult" (Form 2.3). The available electronic versions can be used to complete the report during the assessment interview. Although they are similar in format, the child version emphasizes and prioritizes presenting symptoms, disorders within the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* (American Psychiatric Association, 2000), and standardized tests most pertinent to cases younger than age 18 years, along with more developmentally oriented language and inclusion of a separate "Developmental" section. The adult version is better adapted in these areas for those 18 years and older. These report templates are reviewed simultaneously by section. Key differences are noted where appropriate.

¹ I assume that your group or individual practice has a consent-to-treat form as part of the intake or admissions process. This form is standard for clinical mental health practice and is not unique to assessment and testing. Thus, I do not include such forms in the interest of reducing the length and scope of this book. Similarly, I do not include a release of information form, as it is also not particular to psychological testing.

Patient Identifying Information

This first section is intentionally succinct and includes name, chronological age in years and months, and date of birth. This information can be obtained from the "Test Referral Form" or directly from the patient and family members.

Referral Information

This section begins with identifying the referral source and reasons for the referral, both of which are provided on the "Test Referral Form." The latter incorporates verbatim language from the form's checklist format. Simply retain those that were selected by the referring clinician and delete those that remained unmarked.

Next, list the *DSM-IV-TR* diagnoses that need to be ruled out, along with the referring clinician's current working diagnosis. Also, note any additional referral questions recorded by the referring clinician and list them in order of priority. You may have to modify these questions somewhat without changing their substance to render them amenable to standardized testing. This information may not be available in cases of self-referral. In this event, delete this portion of the referral information section and proceed directly to the presenting symptoms.

Presenting symptoms are enumerated in order of diagnostic classification, with priority assigned on the basis of both frequency and similarity of symptoms. Note the divergence in ordering between the child and adult "Initial Psychological Assessment Report" templates. The child template presents the following order of headings with their common symptoms: ADHD, ODD/CD, PDD, Mood, Anxiety, PTSD, Psychosis, Neuropsychological,

² For clinicians not familiar with the common diagnostic abbreviations, I list them here for convenience: Attention-Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Pervasive Developmental Disorder (PDD), and Posttraumatic Stress Disorder (PTSD).

and Personality.² The order for the adult template is as follows: Mood, Anxiety, PTSD, Psychosis, Neuropsychological, Personality, and ADHD.

Based upon my experience using the clinical method, the selected symptoms are the ones most commonly reported by patients and family members that are most suggestive of each class of disorder. They have been carefully paraphrased in narrative terms based upon more formal *DSM-IV-TR* enumerated criteria (American Psychiatric Association, 2000) so as to indicate the possible presence of these various disorders. The purpose is to enhance the probability of justifying the subsequent testing and to provide some degree of structure to the interview process. Use of the “Test Referral Form” information will permit you to prioritize and adapt the listing for a particular case, and hence reduce valuable interview and writing time. You can easily amend the templates according to your particular referrals and testing cases. Lastly, note that the listing of disorders and their associated symptoms are intentionally phrased in summary terms so as to prevent the interview process from becoming ponderous. Additional symptoms and their disorders may be added as necessary.

The presenting symptoms portion ends with an *onset* course specifier critical for accurately interpreting test data. It should be inquired and recorded for each diagnostic grouping for purposes of reliable and valid diagnosis (e.g., documenting ADHD-type symptoms prior to 7 years of age and identifying premorbid conditions).

Clinical Psychologist

This small section identifies the testing clinician, including name, degree(s), and licensing credentials and numbers. In the State of Indiana wherein I practice, Health Service Provider in Psychology (HSPP) indicates an autonomously functioning psychologist without the need of formal peer supervision. This status, or one equivalent in your state, is a critical credential to list. In the absence of such credential, a supervising psychologist needs to be added to the report.

Mental Status Examination (and Behavioral Observations)

Mental status information covered in both child and adult templates includes the following: (a) affect; (b) mood; (c) thought process and content; (d) short- and long-term memory functioning; (e) sensorium; (f) estimated intellectual functioning based upon verbal skills and reasoning ability; (g) psychotic symptoms; (h) suicidal thoughts, intentions, and plans; and (i) current evidence of self-mutilation and self-harm. The last two assist in assessing imminent danger to self.³

Homicidal thoughts may be assessed and added when presenting symptoms include conduct-disordered behaviors, antisocial traits, or a history of violence. However, I do not include them in the report templates as they are less typical and, in my opinion, appear awkward and displaced when reported as being absent without a remarkable history of violent or aggressive behavior.

The remaining mental status examination information is somewhat divergent between the child and adult templates. The child template adds behavioral observations, including activity level for suspected ADHD, and social skills for suspected PDD. Regarding the adult version, I have prepared three extended mental status examination templates that incorporate as many versions of the Mini-Mental State Examination, Second Edition (Folstein, Folstein, White, & Messer, 2010), in the form of results and interpretation tables. The Mini-Mental State Examination, Second Edition (MMSE-2) is normed on individuals aged 18 years 0 months to 100 years 11 months. I most commonly use them for adult neuropsychological test referrals as an effective screening for *DSM-IV-TR* Cognitive Disorders, and disorders due to brain trauma and resulting neuropsychological

³ Past suicide attempts are diagnostically more pertinent to the presenting symptoms portion of the “Referral Information” section.

dysfunction (e.g., Personality Change Due to Head Trauma). Each version may supplant the standard mental status examination section of the adult template. Next, I review these extended mental status examination templates in more detail.

Mental Status Examination Including the Mini-Mental State Examination, Second Edition

The extended templates cover all of the standard mental status examination information reviewed prior, in addition to a results and interpretation table that has been strategically inserted suitable to each version of the MMSE–2. The table is placed immediately subsequent to information regarding affect, mood, and thought, and prior to memory, sensorium, intelligence, and danger to self.

For all three versions, the MMSE–2 is administered and hand-scored simultaneously. It is published in equivalent blue and red forms for purposes of test–retest comparisons. I utilize the blue form when testing a case for the first time, then substitute the red form upon retesting. Hence, the templates identify the blue form because I use it most frequently in practice. The “Level of Consciousness” qualitative item on both forms may be incorporated into the narrative of the mental status examination if deemed clinically useful.

Also, regarding all MMSE–2 versions, I advise using a cutoff score that maximizes detection of a true positive (i.e., sensitivity). To determine such a cutoff, I scrutinized the reported MMSE–2 scores for individuals with documented Dementia for all three versions (Folstein, Folstein, White, & Messer, 2010). The raw score I chose and reported in each tabular template provides 97% confidence that a true case of neuropsychological disorder is recommended for further testing. For convenience, each tabular template reports the raw score cutoff used and the 97% confidence such threshold affords.

Succinctly, the rationale for employing such high confidence is that a patient is typically referred for neuropsychological testing due to prior observations of rather severe symptoms. It is thus in the best interests of the patient to minimize the chances of a false-negative screen due to the dire consequences of precluding or delaying needed treatment.

MMSE–2 Brief Version

The MMSE–2 version assesses the first four cognitive functions in the original MMSE (Folstein, Folstein, & Fanjiang, 2001) with updated norms including registration (i.e., immediate repetition of three unrelated words), orientation to time and place, and recall (i.e., repeating the same recall words with delay and interference of rehearsal; see Form 2.4). Administration time is minimal and hence its primary advantage over the two longer versions. Of a total possible 16 points, the cutoff for screen positive begins at 14 and lower.

A caveat is that the brief version comprises items that are easy to pass, which offsets to some degree the aforementioned high-detection threshold and risks a ceiling effect. Also, administration of fewer items is less reliable as compared to more items (see e.g., Miller, McIntire, & Lovler, 2011). Thus, I advise that you administer the brief version only in cases where limited time precludes administration of one of the longer versions.

MMSE–2 Standard Version

The MMSE–2 Standard Version assesses all of the cognitive functions included in the original MMSE (Folstein, Folstein, & Fanjiang, 2001), with updated norms and some revised items for greater reliability and validity (see Form 2.5). Thus, it adds attention and calculation (i.e., serial sevens), naming objects, repetition of a phrase, comprehending and reproducing three commands in sequence, reading a sentence and reproducing its instruction, writing a sentence, and copying a two-dimensional figure.

Administration time is 5 to 10 minutes with a total possible raw score of 30. The cutoff for the 97% true positive criterion is 27 and lower. While the standard version is more accurate than the brief version, ceiling effects continue to be possible especially if the patient has a satisfactory educational history. Thus, to maximize the chances of a true positive screening decision and substantiate the ordering of a full neuropsychological test battery, I advise administering the MMSE–2 Expanded Version.

MMSE–2 Expanded Version

The MMSE–2 Expanded Version contains two newly developed items added to the standard version, including *Story Memory*, which measures both verbal explicit learning and verbal free immediate recall, and *Symbol–Digit Coding*, which measures both perceptual-motor speed and incidental learning (Folstein et al., 2010; see Form 2.6). Although it adds 10 minutes administration time (totaling about 15 to 20 minutes for the entire expanded version), these items are difficult to perform adequately in the presence of true neuropsychological dysfunction irrespective of education (Folstein et al., 2010).

The total possible raw score is 90 with a positive screen cutoff of 50 and lower. These final two items add a considerable amount of performance points and a commensurate increase in reliability and validity. I advise prioritizing the MMSE–2 Expanded Version in testing referrals involving prominent cognitive presenting symptoms and in all adult neuropsychological testing referrals. Of course, you do have the flexibility of administering the MMSE–2 Standard Version, and should results provide empirical evidence of a positive screening, defer the final two items in the interests of time.

Psychiatric/Medical/Psychological

This section begins with documentation of whether or not an initial mental health assessment (billing code 90801) was completed within the past year. As indicated prior, it is relevant to internal referrals from mental health clinicians and such information is provided by a properly completed “Psychological Test Referral Form” (see Form 2.1). Additional areas covered in this section regard individual and family psychiatric histories (including a selected listing of common disorders), medical functioning, current medications, brain trauma, seizure disorder, major surgeries, vision and hearing, psychotherapy services, and if any past testing has been done. If the last is affirmative, a brief discussion of the type of testing and basic results is indicated, especially if completed within the past several years. Highlighting such information will ultimately facilitate interpretation of the more current testing.

Developmental

This section is included in the child template only, primarily because the information contained therein is most relevant to individuals in their formative years. However, it can be inserted into the adult template if such information is deemed diagnostically important, especially for young adult cases. Areas of coverage include possible prenatal, perinatal, and postnatal complications, neonatal risk factors, and early developmental milestones. Many of the statements are phrased in normal terms, which can be quickly amended upon the gleaning of more aberrant developmental information.

Family

As a rule, the information in this section should be restricted to the following: (a) objective facts regarding the patient’s current living situation, including with whom the person lives (e.g., spouse, parents, number of siblings) and (b) diagnostically pertinent, although

potentially disputatious, historical or recent stressors impinging on the patient or family system. The latter are important to note when stress-related disorders are being considered in differential diagnosis (e.g., Adjustment Disorders, PTSD, and Acute Stress Disorder).

A caveat here is that such stressors should be phrased prudently using nonspecific terms and invariably preceded by the qualifying word *reported*, such as “There is a *reported* history of child neglect” or “There is currently some *reported* unresolved conflict within the parental dyad.” This qualifying word communicates to readers that you are basing your assessment on interviewees’ statements or archival records for the purpose of facilitating diagnosis, not as an offer of proof or of objective fact. This tenet applies wherever you decide to place such information, whether it be in this “Family” section or among the presenting symptoms. Following this rule will effectively attenuate the odds that your report will be used to inflame family and legal disputes, while retaining its diagnostic value.

Interpersonal

This section focuses on significant nonfamily relationships. Regardless of whether it is a child or adult case, you essentially want to document whether or not such relationships have been satisfactory in terms of quality or intimacy, and secondarily in terms of quantity. In case of poor quality and quantity, some comments regarding the suspected reason(s) are indicated, including ineffectual social skills, chronic mistrust, fear of rejection, excessive dependency, or simply being associated with the presenting symptoms. If you effectively document remarkable interpersonal trends, this section may be both pithy and diagnostically efficacious.

Educational

The information covered in this section varies somewhat in emphasis between the child and adult templates. The former highlights the current grade level, differentiates academic and behavioral performance, grade retention, and special education services and classification (i.e., learning disability [LD], emotional handicap [EH]). The latter prioritizes total years of formal education (critical for determining proper neuropsychological testing norms), date of high school graduation, academic performance, grade retention, and special education services and classification.

Vocational

The default on the child template is “None,” because this will be accurate in the majority of child cases. If an adolescent is employed, his or her work history will not be extensive and the information may be entered in succinct fashion. The adult form presents the most common alternatives, including current or past occupation, job status (i.e., unemployed, retired), and the general course of work history (e.g., consistent, sparse, erratic).

Substance Abuse

The default for both child and adult forms is “Unremarkable.” The reason is that the majority of testing referrals, especially those from mental health clinicians, have already addressed whether or not a substance-related disorder exists and do not reference this as a diagnostic question. This is due to the fact that the clinical method is useful for diagnosing substance-related disorders, including the discernment of normal use, abuse, and dependence (Barlow & Durand, 2012). The most frequent differential diagnostic testing referral questions regarding substance abuse include ruling out the following: (a) Substance-Induced Persisting Dementia and Amnesic Disorder and (b) risk for later development of substance abuse and dependence based upon current Axis I and II psychopathology

(including family history). If remarkable, this information can usually be summarized from the information recorded by the referring clinician on the “Psychological Test Referral Form” under “Current working diagnosis(es).”

Legal

If you practice in general mental health, the most frequent entry for both child and adult cases regarding legal criminal history will most likely be “Unremarkable.” Thus, I have recorded this as the default wording. In the event you regularly receive testing cases that ask you to rule out Conduct Disorder and Antisocial Personality Disorder, I recommend that you create a custom-designed template for this section of the report to reduce typing time.

Initial Assessment Summary

This penultimate section of the “Initial Psychological Assessment Report” first incorporates the final section by reference, which enumerates the current provisional working *DSM-IV-TR* diagnosis(es), ensued by those that need to be *ruled out* (i.e., tested for whether or not they exist). It then provides a rationale for requesting standardized testing, beginning with the need to rule out the stated *DSM-IV-TR* disorders, addressing any related referral questions noted in the “Referral Information” section, and, particularly concerning neuropsychological testing referrals, empirically measuring the nature and extent of neuropsychological deficits for purposes of treatment planning. The latter recognizes the dimensional facet of Cognitive Disorders in terms of differentiating mild, moderate, and severe cases critical for treatment planning and resolving placement decisions (e.g., independent living, assisted living, nursing home care).

Immediately subsequent is an enumeration of all the standardized tests contained in my recommended inventory, differentiated on the basis of child (18 years and younger) and adult (18 years and older). Specific test information includes test name, abbreviation, form, type of subtest battery, if applicable (e.g., full battery, screening battery), and *maximum* estimated hours per test. I advise not exceeding these estimates, and reducing them as frequently as is feasible in order to remain within a 3- to 5-hour range. Although the proper age range for some of the child tests may be determined by the form’s name, this information is generally not available on the “Initial Psychological Assessment Report” templates as it would become ponderous.

However, the age range for which each test has been standardized is available on the “Psychological Test Listing Form” (see Form 2.7) and should be readily available to the psychologist during the initial psychological assessment process if needed to facilitate the proper selection of tests. The tests are classified by either psychological construct or test format, whichever way they are most readily identified and are enumerated in the same order as presented in Section II of this book. Specific information recorded on this form includes test name, abbreviation, and age range in years and months.

Although a request for one additional test hour for purposes of data integration and report composition is also listed, I am currently using this infrequently if not at all because it is not likely to be approved. It is probable that I will eventually remove this option from the templates as it simply affords insurance companies an opportunity to reduce your request by 1 hour. Therefore, I believe this time is more effectively incorporated into the time estimate for each individual test or combination of tests, which should be coded as either neuro-psychological testing (billing code 96118) or standard psychological testing (billing code 96101). An issue for which there currently does not exist uniform guidelines

regards the most accurate means of assigning these dichotomous billing codes to the number of testing hours requested. Thus, I shall next enumerate several billing code assignment strategies.

In my experience, there are four viable strategies for assigning the two billing codes to the requested testing hours. Succinctly, they include the following: (a) If any test in the battery is neuropsychological, code all requested testing hours as neuropsychological (i.e., billing code 96118), otherwise code them all as standard psychological testing (i.e., billing code 96101). (b) Differentiate the requested testing hours by their fundamental design using the “Psychological Test Listing Form” (Form 2.7) as your guide. (c) Code all testing hours according to the prevailing diagnostic issues and any related questions. (d) Code all testing hours according to the type of tests and testing hours that comprise the vast majority within the particular battery. I shall expound on each of these strategies in this sequence, then conclude with some general suggestions on when and how they may be most effectively implemented.

First, as a rule of efficiency, if the test battery in whole or in part includes a neuro-psychological test or test battery, I simply total the number of requested hours and code it as such (i.e., billing code 96118). Otherwise, I classify the total as standard psychological testing (i.e., billing code 96101). The primary reasons include the following: (a) this distinction is becoming increasingly nebulous, commensurate with mounting evidence of neuropsychological dysfunction being associated with many Axis I *DSM-IV-TR* psychological disorders (Barlow & Durand, 2012); (b) the differential billing is cumbersome and thus can potentially become paradoxically more imprecise; (c) the charge per testing hour is identical (i.e., at least where I practice), rendering the distinction meaningless from a strict pecuniary perspective; and (d) the specific tests and hours being requested are explicitly listed in the “Initial Psychological Assessment Report” for scrutiny by the insurance company. I have rarely encountered insurance coverage difficulties by employing this parsimonious bill coding strategy. In the event the insurance company diverges in opinion, simple coding adjustments can be readily made.

Second, a viable alternative is to differentiate the billing hours according to type of test, psychological and neuropsychological, as I have indicated on the “Psychological Test Listing Form” (Form 2.7). When using this strategy, it is important to incorporate any time necessary for data integration and report writing into that estimated for the individual tests, a practice I endorse irrespective of bill coding strategy. For example, if I order the Rorschach Inkblot Test, Comprehensive System, RIAP, Fifth Edition, and the NEPSY–II Social Perception Subtests, the requested test hours would be 2 hours psychological testing (i.e., billing code 96101) and 1-hour neuropsychological testing (i.e., billing code 96118), respectively, and billed as such assuming approval. However, this method is more unwieldy because you are requesting two separate psychological services within the same testing case, which requires enhanced fastidiousness regarding the documentation and ultimate accuracy of your billing.

The third option is to request the type of testing service according to the principal diagnostic issues and any related questions. Thus, for example, if Personality Change Due to Brain Trauma is being ruled out, all requested testing hours would be coded neuropsychological (i.e., billing code 96118), irrespective of the fact that a standard psychological test may have been added as ancillary to the neuropsychological test battery in order to determine the nature and extent of maladaptive personality traits. The problem with this strategy arises when referrals include the need to rule out both cognitive disorders and more typical psychological disorders, especially those with increasing evidence of underlying neurocognitive dysfunction (e.g., PDD, ADHD).

The fourth and final strategy is to request the one billing code that is the best representative of the entire test battery; that is, whether it is more dominated by neuropsychological or standard psychological tests. For example, if the test battery largely

consists of neuropsychological tests, all requested testing hours would be coded 96118 and vice versa.

My general advice is to routinely employ the fourth option, which shall be frequently accordant with option three, although be prepared to supplant this with the most viable alternative that best matches the unique nature of the testing case or insurance company standards. Again, occasional inconsistencies with the criteria of a particular insurance company are typically not fatal, and simple and rapid modifications are more than feasible. Furthermore, with experience you shall become increasingly familiar with the various standards of independent insurance companies and will learn to employ the most conducive strategy. Perhaps the billing code distinction between neuropsychological and psychological testing shall eventually be dropped as obsolete and antiquated, analogous to the now defunct Organic versus Inorganic Mental Disorders distinction espoused by the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R)* (American Psychiatric Association, 1987). Until then, however, the above options can be useful practice billing code guidelines.

Finally, the initial assessment summary section concludes with an attestation that the requested test or tests are (a) standardized properly for the patient's age and (b) are in their most recently published editions. Both are critical for test approval and are consistent with the ethical principles for psychologists (American Psychological Association, 2003).

Pretest DSM-IV-TR Diagnoses

With its reliance on the clinical method, one of the essential goals of the initial assessment is to efficaciously narrow the scope of *DSM-IV-TR* disorders to those most likely to be present. This permits focus and precision for the planned follow-up standardized testing. The most logical place to record such information is in the ultimate section of the report employing the familiar *DSM-IV-TR* multiaxial system (American Psychiatric Association, 2000).

The Axis I pretest provisional working diagnoses listed in the templates emphasize the most general Not Otherwise Specified (NOS) disorders, followed by stress-induced Adjustment Disorders, and, regarding the child template, occasionally relevant "995" maltreatment victim-focused codes. This is accordant with my thesis that the clinical method has limited utility in resolving more particularly defined differential diagnostic questions. The provisional working diagnoses are ensued by a more comprehensive (although not exhaustive) listing of the most frequent specific *DSM-IV-TR* disorders, which are the focus of standardized testing.

The child and adult Axis I listings are prioritized somewhat differently, consistent with the different prevalence rates and types of disorders in these age groupings. Axes II, III, and IV are analogously prioritized. The Axis V Global Assessment of Functioning (GAF) default is set at moderate to severe (about 45 to 55) as the most frequently occurring range, although if psychotic symptoms are evident in the presenting symptoms and/or mental status examination, 35 and lower is most appropriate. Standardized psychological testing will probably not be approved for higher ratings as being neither necessary nor cost-effective. Finally, a deferral on prognosis is made due to the provisional status of pretest working diagnoses.

REVIEWING THE PRELIMINARY FINDINGS AND PLANS FOR TESTING WITH PATIENTS

Use of the "Initial Psychological Assessment Report" provides structure and focus to the clinical interview process. It can be completed well within the standard 50-minute clinical hour.⁴ Patients, pertinent family members, and guardians should be informed of the

⁴ Once the initial report is completed, I save it on an external USB flash drive in a folder titled "INITIAL PSYCHOLOGICAL ASSESSMENTS." I save the patient's particular report beginning with "I" for initial, followed by an underline mark "_", last name, first name, and office file number; for example, I_Smith, Mary 233878. The initial reports will be saved by most computer software alphabetically for ease of location. In cases where I conduct a second initial evaluation, for example, a referral for retesting at a later date, I use "II"; for example, II_Smith, Mary 233878. Of course, I back up all saved files on a second USB flash drive.

following: (a) provisional *DSM-IV-TR* diagnoses, (b) all suspected *DSM-IV-TR* diagnoses in need of being ruled out and related referral questions to be answered, (c) the planned standardized test battery, and (d) estimated number of testing hours.⁵ The tests in the planned battery should logically follow from the rule out diagnoses and questions reviewed prior. Section II of this book details the capabilities of each test in the “Psychological Test Listing Form” for purposes of differential diagnosis, supplemented by their respective scoring and interpretation tabular templates.

Finally, information outlining the remaining steps in the testing process should be provided such that patients and their significant relationships are sufficiently cognizant of what to expect. To expedite affording such information, I have prepared a written “Patient Test Instruction Form,” discussed immediately subsequent (see Form 2.8).

Patient Test Instruction Form

Item 1 informs patients that the standardized testing must be preauthorized by their insurance carrier using the initial report. Item 2 explicitly states the maximum number of testing hours being requested. Of crucial importance, it also educates patients and their families regarding the core tasks that contribute to the testing hours. Item 2 information will obviate later misunderstandings, as some laypeople possess a misconception that charges should be limited to face-to-face administration time. This partly may be due to a confusion between individual psychotherapy services (i.e., billing code 90806), which are based strictly upon direct service time (e.g., the 50-minute hour), and psychological testing services, which require a significant number of billing activities without the patient being present. The purpose of item 3 is to inform patients of the number and duration of testing appointments, assuming that all or the majority of requested testing hours are approved. It requires the testing psychologist to enter this information in writing; for example “One 2-hour appointment.” I advise not exceeding a duration of 2 hours for a single testing session, irrespective of age due to potentially confounding fatigue effects. As should become increasingly apparent as you proceed through this book, with the exception of administering complete neuropsychological test batteries, the majority of test administrations can and should be completed within a single 2-hour appointment.

Item 4 is to ensure that any symptom rating scales that are part of the planned test battery (see Form 2.7, section “Symptom Rating Scales”), which are submitted to patients and accompanying family members at the conclusion of the initial report, are properly completed and returned to the testing psychologist. The language contained therein reinforces their central role in the testing process. If this item does not apply, simply cross it out and place *N/A* adjacent to it. It may be of assistance to explain orally to patients that this item is not applicable in their case and for them to simply ignore it.

Item 5 addresses any self-report inventories which may be included in the test battery (see Form 2.7, section “Self-Report Personality Inventories”), which for standardized test security reasons must be completed on site. The item instructs patients to complete the inventory upon being informed that testing has been authorized. I recommend purchasing computer-administered versions of these tests for immediate automated scoring (see Chapter 8).

Patients should be encouraged to complete such inventories on a day prior to any scheduled test administration appointments for purposes of expediency and to mitigate confounding fatigue effects. If the inventories are loaded upon a single computer, it is prudent to have them call your office in advance to determine availability. Again, if this item does not apply, simply cross it out, place *N/A* adjacent to it, and reinforce this orally to patients and family members.

Item 6 elucidates the type of services and considerable amount of work completed subsequent to the test administration process, including scoring, interpretation, and report writing. This disabuses patients of the notion that completion of test administration is synonymous with concluding the assessment and testing process. Furthermore, it corroborates the number

⁵ Again, I assume that your group or individual practice has a standard treatment plan form upon which the clinician records the plan for testing and/or intervention, including signature lines for patients, pertinent family members, guardians, and clinicians indicating their mutual agreement and approval. This form is also standard for clinical mental health practice and is not unique to assessment and testing. Thus, I again do not include such forms in the interest of saving space.

of testing hours requested when reviewing the initial assessment results with patients, and elucidates the reason why patients are ultimately charged for testing hours in excess of face-to-face contact. Finally, item 6 reminds patients and pertinent family members of the recommended feedback session to be conducted subsequent to completion of the final report.

Item 7 concludes the instruction form. It specifically pertains to obtaining the necessary release of information in order to properly communicate the results to referring clinicians and other relevant third parties. Many mental health offices have release of information forms that are HIPPA compliant, and are specifically designed for their services and within their jurisdictions. For this reason, I advise you use the release form that has been approved within your practice and jurisdiction (see e.g., Missouri Bar, 2006).

Obtaining Insurance Precertification

The completed “Initial Psychological Assessment Report” may be submitted for insurance authorization immediately after the conclusion of the clinical interview. I advise not scheduling test administration appointments or self-report clinical and personality inventories prior to insurance authorization. This is due to uncertainty as to which tests and quantity of test hours will be ultimately approved. For expediency, I do recommend submitting any symptom rating scales to patients and family for completion prior to authorization, ideally in proximity to reviewing the tests in the requested battery.

Noting the Number of Test Hours Approved

In my experience, either all or the vast majority of requested test hours are routinely approved under the following two conditions: (a) fastidious use of the “Initial Psychological Assessment Report” templates and (b) judicious adherence to remaining within the advised three to five test hour request range (again with the limited exception of full neuropsychological test batteries). However, occasionally testing hours may be denied outright or circumscribed (e.g., 1–2 hours versus 3–5 requested). In these cases, I recommend administering the entire planned battery for the following reasons: (a) these decisions are infrequent and are offset by the greater number of successful authorizations for testing, (b) this bolsters a salutary professional reputation for providing high-quality services, (c) the time elapsed with an insurance company appealing a case for more hours is cost ineffective, and (d) this ultimately assists in reducing human suffering (which I assume is an essential goal of people entering the helping professions, such as psychology).

Another option is to negotiate a reduced out-of-pocket fee with the patient or authorized family members. This alternative is much less desirable as it requires the agreement be reduced to writing, and necessitates further decisions, including whether you require advanced payment to be placed into trust until service is completed. Finally, I advise against proceeding with a reduced test battery for the following three reasons: (a) the insurance company’s authorization will be based upon your recommended test battery, (b) such reduction increases your liability for malpractice, and (c) the difficulty encountered when attempting to rationalize such reduction with the patient and pertinent family members.

In the event testing is denied, I suggest discovering the reasons therefore and attempting to amend the “Initial Psychological Assessment Report” with the additional required information prior to resubmission. The remaining alternatives are (a) negotiating an out-of-pocket fee arrangement as described prior, (b) not proceeding with standardized testing, (c) completing the testing case pro bono due to hardship, or (d) referring to a psychologist or agency who will complete such testing for a reduced fee or pro bono. To effectively record the progress of a testing case, I have prepared a form titled “Psychological Test Request and Log Form” that is discussed next (see Form 2.9).

Psychological Test Request and Log Form

This form represents a rapid reference sheet that tracks a testing case from completion of the initial report to case termination or discharge. It is effective for both the testing psychologist and support staff so as to contact a case as needed, schedule appointments properly, and accurately note case progress.

The form logically begins with patient identification and contact information. The ensuing section notes the requested number and duration of test administration appointments, which should be accordant with that recorded on the “Patient Test Instruction Form.” Analogously, the next section includes any self-report clinical and personality inventories that may have been ordered as part of the battery such that the patient may be reminded to complete this upon test authorization. If this does not apply, simply enter N/A as on the “Patient Test Instruction Form.”

Subsequent essential information includes the following: (a) type of testing (i.e., psychological or neuropsychological) and number of hours *requested*, (b) type of testing (i.e., psychological or neuropsychological) and number of hours *approved*, and (c) whether or not insurance authorization for testing is required and dates of approval, or alternatively, for those without insurance coverage, a selection for self-pay and the negotiated fee. Insurance authorized dates of approval permits the testing psychologist to prioritize the scheduling of administration appointments such that the testing process does not exceed the duration.

SUMMARY

This chapter delineated the initial phases of the psychological testing process from the initial referral to the scheduling of test administration appointments. They are considered critical in that, if mismanaged, the remaining phases are consequently hindered or precluded. Chapter 3 discusses the final two phases, including (a) completion of the final psychological evaluation report and (b) communication of the assessment and test results (see Figure 1.1).

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FORM 2.1

**NAME OF PRACTICE
PSYCHOLOGICAL TEST REFERRAL FORM**

Patient Name: _____ **Patient DOB:** _____
(Last) (First)

Account or Patient File #: _____ **Referral date:** _____

Referring Clinician Information: _____

Individual, Agency		Street Address		
City	State	Zip Code	Office Phone	Office Fax

Mark one: Psychological Testing; Neuropsychological Testing
(needs physician consultation and approval).

The testing referral is needed because (mark all that apply):

- Diagnosis remains ambiguous subsequent to clinical interview, examination, and ongoing observation.
- There has been poor or no response to treatment intervention for undetermined reasons.
- Objective standardized testing will significantly impact treatment planning and outcome.

Behavioral Health Evaluation Date (i.e., 90801) (Mental Health Clinicians Only): _____

Current working diagnosis(es): _____

Diagnosis(es) to be ruled out: _____

Note: As a general practice, health insurance will not authorize the following: (a) educational or vocational testing, and (b) court-ordered psychological testing.

Additional referral question(s) (if any): _____

Mood: dysphoria, irritability, sad mood, fatigue, agitation, lack of interest, social withdrawal, flat affect, blunted affect, excessive guilt, low self-worth, periodic suicidal thoughts, severe mood swings vacillating from euphoria to dysphoria, affective instability, sleep and appetite problems, racing thoughts, grandiosity, impulsive and risky behaviors, distractibility, and diminished attention and concentration.

Anxiety: chronic apprehension, irritability, muscle tension, restlessness, becoming easily fatigued, sleep problems, periods of intense panic, trembling, difficulty breathing, racing heart, sweating, dizziness, feelings that things and people are not real, feeling detached, nausea, and feelings of terror and dread.

PTSD: exposure to severe trauma with subsequent response of intense fear and horror, repeated nightmares of the trauma, repeated memories of the trauma while awake, behaving as if the trauma was occurring, hypervigilance to anticipated danger, observed startle response, irritability, and anger outbursts.

Psychosis: auditory disturbances including hearing voices without knowing their source, visual disturbances including seeing things that are not actually present, tangential, disorganized, and fragmented speech, flat affect, inappropriate affect, ideas of persecution and grandeur, lack of volition, lost interest, poverty of speech, social withdrawal, and disorganized behavior.

Neuropsychological: reduced awareness of the environment, reduced ability to focus, shift, and sustain attention, disorientation, periods of mental confusion, impairments in immediate and intermediate memory, difficulties retrieving words when speaking to others, using words inappropriately, reduced ability to comprehend the spoken language of others, difficulties recognizing and naming objects, increasing motor dysfunction including loss of balance, motor incoordination, becoming lost and disoriented when navigating familiar routes, and a noticeable decline in forethought, organizing, and logical abstract reasoning abilities.

Personality: chronic difficulties establishing and maintaining interpersonal relationships of adequate intimacy, instability of interpersonal relationships, unstable self-image and sense of self, affective instability including intense episodic dysphoria lasting hours to days, inappropriate intense anger, episodes of self-mutilation in the form of cutting when experiencing dysphoria with dissociation of pain, repeated suicidal behavior, feelings of emptiness, intense fear of abandonment, impulsivity, failing to follow social norms, chronic lying, frequently disregarding the basic rights of others, aggressiveness, irresponsibility, lack of guilt or remorse, low self-worth, lack of self-confidence, fear of embarrassment and humiliation, excessive dependency on others, need to be the center of attention, and shallow and dramatic emotional expression.

Onset was estimated to be: _____.

Clinical Psychologist:

Psychologist Name, PhD, PsyD, HSPP _____

Psychologist – State License # _____

Mental Status Examination and Behavioral Observations:

Affect was _____. Mood was _____. Thought process was logical, sequential, relevant, and coherent. Thought content was reality-based and normal. Short-term memory functioning was _____. Long-term memory functioning was normal and intact, as evidenced by _____'s ability to provide age-appropriate historical information. _____ was oriented to time, place, and person. Activity

level was normal. Social skills were normal including effective eye contact and reciprocity. Estimated intellectual function based on verbal skills and reasoning abilities is average. Psychotic symptoms were not evident. There was no evidence of suicidal thoughts, intentions, or plans. There was no evidence of self-mutilation or self-harm.

Psychiatric/Medical/Psychological:

The referring clinician completed a Behavioral Health Evaluation (i.e., 90801) in or about _____. No Behavioral Health Evaluation (i.e., 90801) has been done within the past year. Psychiatric history includes outpatient treatment by _____. Family psychiatric history is negative positive for ADHD, Bipolar Disorder, Depressive Disorder, Schizophrenia, Dementia, and Learning Disorder. Medical functioning is unremarkable remarkable for. _____ is not taking any current medications. Current medications include _____. There is a negative history of severe head injuries, seizure disorder, and major surgeries. Vision is normal. Hearing is normal. _____ has been in psychosocial therapy for _____. Previous neuropsychological testing has not been done.

Developmental:

There were no pre-, peri-, or post-natal complications reported. Gestation was full-term. Birth weight was _____ pounds _____ ounces. Birth length was _____ inches. Developmental milestones were reported as falling within the normal range.

Family:

_____ lives with _____.

Interpersonal:

Interpersonal relationships were described as satisfactory in both quality and quantity. Social skills were described as ineffectual with deficits in friendships of adequate intimacy.

Educational:

_____ is in Grade _____. Academic performance has typically been _____. Behavioral grades have typically been _____. There has been no grade retention. _____ was retained in Grade _____, is receiving general special education instruction, has a continuing IEP, and is classified as _____.

Vocational:

None.

Substance Abuse:

Unremarkable.

Legal:

Unremarkable.

Initial Assessment Summary:

Based upon the initial psychological assessment evidence, pre-test working diagnosis and disorders needed to be ruled out are listed below in the ensuing *Pretest DSM-IV-TR Diagnosis* section. The test data shall also provide answers to the additional referral questions listed above in the *Referral Information* section of this report. The test data shall also empirically measure the extent and severity of any neuropsychological deficits for purposes of treatment planning.

The following tests and estimated hours are requested:

1. NEPSY–II, Form Ages 5 to 16, Attention and Executive Functioning, Memory and Learning Subtests (2 hours)
2. Conners' Continuous Performance Test, Second Edition, Version 5 (CPT–II) (1 hour)
3. Conners Comprehensive Behavior Rating Scales (Conners CBRS), Parent and Teacher Forms (1 hour)
4. Conners Comprehensive Behavior Rating Scales (Conners CBRS), Parent and Self-Report Forms (1 hour)
5. Conners Comprehensive Behavior Rating Scales (Conners CBRS), Parent, Teacher, and Self-Report Forms (2 hours)
6. Conners Comprehensive Behavior Rating Scales (Conners CBRS), Self-Report Form (1 hour)
7. NEPSY–II, Form Ages 3 to 4, Attention and Executive Functioning, Memory and Learning Subtests (2 hours)
8. Conners' Kiddie Continuous Performance Test, Version 5 (K–CPT) (1 hour)
9. Conners Early Childhood (Conners EC), Parent and Teacher/Childcare Forms (1 hour)
10. NEPSY–II, Form Ages 3 to 4, Full Battery (6 hours)
11. NEPSY–II, Form Ages 5 to 16, Full Battery (8 hours)
12. NEPSY–II, Form Ages 3 to 4, General Battery (3 hours)
13. NEPSY–II, Form Ages 5 to 16, General Battery (4 hours)
14. NEPSY–II, Form Ages 3 to 4, Social Perception Subtests (1 hour)
15. NEPSY–II, Form Ages 5 to 16, Social Perception Subtests (1 hour)
16. NEPSY–II, Form Ages 3 to 4, Attention and Executive Functioning, Memory and Learning, Social Perception Subtests (3 hours)
17. NEPSY–II, Form Ages 5 to 16, Attention and Executive Functioning, Memory and Learning, Social Perception Subtests (3 hours)
18. Gilliam Autism Rating Scale, Second Edition (GARS–2) (1 hour)
19. Gilliam Asperger's Disorder Scale (GADS) (1 hour)
20. Millon Pre-Adolescent Clinical Inventory (M–PACI) (1 hour)
21. Millon Adolescent Clinical Inventory (MACI) (1 hour)
22. Minnesota Multiphasic Personality Inventory–Adolescent (MMPI–A) (1 hour)
23. Rorschach Inkblot Test, Comprehensive System, RIAP Fifth Edition (Rorschach–CS) (2 hours)
24. Roberts–2 (2 hours)
25. Vineland Adaptive Behavior Scales, Second Edition (Vineland–II) (2 hours)
26. Wechsler Intelligence Scale for Children, Fourth Edition (WISC–IV) (3 hours)
27. Wechsler Preschool and Primary Scale of Intelligence, Third Edition, Form Ages 2:6 to 3:11 (WPPSI–III, Form Ages 2:6 to 3:11) (2 hours)
28. Wechsler Preschool and Primary Scale of Intelligence, Third Edition, Form Ages 4:0 to 7:3 (WPPSI–III, Form Ages 4:0 to 7:3) (3 hours)
29. Wechsler Adult Intelligence Scale, Fourth Edition (WAIS–IV) (3 hours)
30. Wechsler Individual Achievement Test, Third Edition, Pre-Kindergarten (WIAT–III, PK) (2 hours)
31. Wechsler Individual Achievement Test, Third Edition, K–12 (WIAT–III, K–12) (3 hours)
32. Ability–Achievement Discrepancy Analysis (1 hour)
33. Wechsler Memory Scale, Fourth Edition (WMS–IV), Form Ages 16 to 69 (3 hours)
34. Ability, Memory Discrepancy Analysis (1 hour)

One (1) additional hour is requested for data integration and report composition.

Total requested neuropsychological testing hours is (Billing Code 96118). Psychological testing hours is (Billing Code 96101).

Finally, one (1) individual hour (Billing Code 90806) is requested for follow-up test feedback session and treatment planning.

All of the above-enumerated tests have sufficient empirically derived reliability and validity, and are age-appropriate. Furthermore, these tests are the most recently published editions.

The above-enumerated test has sufficient empirically derived reliability and validity, and is age-appropriate. Furthermore, this test is in its most recently published edition.

Pretest DSM-IV-TR Diagnoses:

Axis I:

- 312.9 Disruptive Behavior Disorder NOS
- 296.90 Mood Disorder NOS
- 311 Depressive Disorder NOS
- 296.80 Bipolar Disorder NOS
- 300.00 Anxiety Disorder NOS
- 298.9 Psychotic Disorder NOS
- 294.9 Cognitive Disorder NOS
- 309.0 Adjustment Disorder With Depressed Mood
- 309.24 Adjustment Disorder With Anxiety
- 309.28 Adjustment Disorder With Mixed Anxiety and Depressed Mood
- 309.3 Adjustment Disorder With Disturbance of Conduct
- 309.4 Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
- 309.9 Adjustment Disorder, Unspecified
- 995.54 Physical Abuse of Child
- 995.53 Sexual Abuse of Child
- 995.52 Neglect of Child

Provisional, Rule Out:

- 314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type
- 314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
- 314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
- 313.81 Oppositional Defiant Disorder
- 312.81 Conduct Disorder, Childhood-Onset Type
- 312.82 Conduct Disorder, Adolescent-Onset Type
- 312.89 Conduct Disorder, Unspecified Onset
- 299.00 Autistic Disorder
- 299.80 Asperger's Disorder
- 299.80 Pervasive Developmental Disorder NOS (Atypical Autistic Disorder)
- 313.89 Reactive Attachment Disorder, Inhibited Type and Disinhibited Type
- 300.4 Dysthymic Disorder, Early Onset
- 296.22 Major Depressive Disorder, Single Episode, Moderate
- 296.32 Major Depressive Disorder, Recurrent, Moderate
- 301.13 Cyclothymic Disorder, Early Onset
- 296.62 Bipolar I Disorder, Mixed, Moderate
- 296.89 Bipolar II Disorder

- 300.02 Generalized Anxiety Disorder
- 309.81 Posttraumatic Stress Disorder, Chronic
- 300.3 Obsessive-Compulsive Disorder
- 295.20 Schizophrenia, Undifferentiated Type, Childhood Onset
- 294.9 Mild/Moderate/Severe Neurocognitive Disorder (Cognitive Disorder NOS)
- 293.83 Mood Disorder Due to a General Medical Condition
- 310.1 Personality Change Due to a General Medical Condition
- 315.00 Reading Disorder
- 315.01 Mathematics Disorder
- 315.2 Disorder of Written Expression
- 315.9 Learning Disorder NOS
- 315.39 Phonological Disorder
- 315.31 Expressive Language Disorder
- 315.32 Mixed Receptive-Expressive Language Disorder
- 315.4 Developmental Coordination Disorder
- 307.0 Stuttering
- 307.6 Enuresis (Not Due to a General Medical Condition), Nocturnal/Diurnal
- 787.6 Encopresis With Constipation and Overflow Incontinence
- 307.7 Encopresis Without Constipation and Overflow Incontinence

Axis II:

- V71.09 No Diagnosis
- 799.9 Diagnosis Deferred

Rule Out:

- 317 Mild Mental Retardation
- 318.0 Moderate Mental Retardation
- 301.83 Borderline Personality Disorder
- 301.81 Narcissistic Personality Disorder

Axis III:

- No Contributory or Pertinent Medical Disorders Noted
- History of Traumatic Brain Injury (TBI)
- Preterm Birth with Low Birth Weight
- History of Meningitis
- Prenatal Exposure to Teratogens
- History of Lead Poisoning
- 250.00 Diabetes Mellitus, Type II
- 850.9 Concussion
- 345.10 Epilepsy, Grand Mal

Axis IV:

- Psychosocial Stressors – Social, Educational, Medical

Axis V:

- Global Assessment of Functioning (GAF): 45 Serious Moderate symptoms
- Prognosis: Deferred pending neuropsychological assessment and test results

Psychologist Name, PhD, PsyD, HSPP
Psychologist – State License # _____

FORM 2.3**NAME OF PRACTICE
OFFICE TYPE—OUTPATIENT DEPARTMENT
INITIAL PSYCHOLOGICAL ASSESSMENT REPORT—ADULT**

Patient Name: _____
(Last) (First)

Account Number: _____

Date: _____

Patient Identifying Information:

Chronological age is years months. Gender is female. DOB: --/--/----.

Referral Information:

The referral source is MD DO PhD, HSPP PsyD, HSPP MA, LMHC, MSW, LCSW, who indicated that the diagnosis remains ambiguous subsequent clinical interview, examination, and ongoing observation, there has been poor or no response to treatment intervention for unknown reasons, and objective standardized testing will significantly impact treatment planning and outcome.

The stated *DSM-IV-TR* diagnoses needed to be ruled out include _____.

Additional referral questions included:

1. _____
2. _____

Presenting symptoms included:

Mood: dysphoria, irritability, sad mood, fatigue, agitation, lack of interest, social withdrawal, flat affect, blunted affect, excessive guilt, low self-worth, periodic suicidal thoughts, severe mood swings vacillating from euphoria to dysphoria, affective instability, sleep and appetite problems, racing thoughts, grandiosity, impulsive and risky behaviors, distractibility, and diminished attention and concentration.

Anxiety: chronic apprehension, irritability, muscle tension, restlessness, becoming easily fatigued, sleep problems, periods of intense panic, trembling, difficulty breathing, racing heart, sweating, dizziness, feelings that things and people are not real, feeling detached, nausea, and feelings of terror and dread.

PTSD: exposure to severe trauma with subsequent response of intense fear and horror, repeated nightmares of the trauma, repeated memories of the trauma while awake, behaving as if the trauma was occurring, hypervigilance to anticipated danger, observed startle response, irritability, and anger outbursts.

Psychosis: auditory disturbances including hearing voices without knowing their source, visual disturbances including seeing things that are not actually present, tangential, disorganized, and fragmented speech, flat affect, inappropriate affect, ideas of persecution and grandeur, lack of volition, lost interest, poverty of speech, social withdrawal, and disorganized behavior.

Neuropsychological: reduced awareness of the environment, reduced ability to focus, shift, and sustain attention, disorientation, periods of mental confusion, impairments in immediate and intermediate memory, difficulties retrieving words when speaking to others, using words inappropriately, reduced ability to comprehend the spoken language of others, difficulties recognizing and naming objects, increasing motor dysfunction including loss of balance, motor incoordination, becoming lost and disoriented when navigating familiar routes, and a noticeable decline in forethought, organizing, and logical abstract reasoning abilities.

Personality: chronic difficulties establishing and maintaining interpersonal relationships of adequate intimacy, instability of interpersonal relationships, unstable self-image and sense of self, affective instability including intense episodic dysphoria lasting hours to days, inappropriate intense anger, episodes of self-mutilation in the form of cutting when experiencing dysphoria with dissociation of pain, repeated suicidal behavior, feelings of emptiness, intense fear of abandonment, impulsivity, failing to follow to social norms, chronic lying, frequently disregarding the basic rights of others, aggressiveness, irresponsibility, lack of guilt or remorse, low self-worth, lack of self-confidence, fear of embarrassment and humiliation, excessive dependency on others, need to be the center of attention, and shallow and dramatic emotional expression.

ADHD: difficulty sustaining attention, becoming easily distracted, being continuously forgetful, difficulty listening to others, disorganization, mind-wandering, failing to complete tasks, acting without considering consequences, fidgeting, difficulty remaining seated, and overactivity. These symptoms have an early onset prior to the age of 7 years, have been chronic, and associated with low academic achievement and work productivity.

Onset was estimated to be: _____.

Clinical Psychologist:

Psychologist Name, PhD, PsyD, HSPP _____

Psychologist – State License # _____

Mental Status Examination:

Affect was _____. Mood was _____. Thought process was logical, sequential, relevant, and coherent. Thought content was reality-based and normal. Short-term memory functioning was _____. Long-term memory functioning was normal and intact, as evidenced by _____'s ability to provide a coherent developmental history with key historical dates. Was oriented to time, place, and person. Estimated intellectual function based on verbal skills, fund of general knowledge, and abstract reasoning abilities is average. Psychotic symptoms were not evident. There was no evidence of suicidal thoughts, intentions, or plans. There was no evidence of self-mutilation or self-harm.

Psychiatric/Medical/Psychological:

The referring clinician completed a Behavioral Health Evaluation (i.e., 90801) in or about _____. No Behavioral Health Evaluation (i.e., 90801) has been previously done within the past year. Inpatient psychiatric history is _____. Family psychiatric history is negative positive for ADHD, Bipolar Disorder, Depressive Disorder, Schizophrenia, Dementia, and Learning Disorder. Medical functioning is unremarkable remarkable for _____. Current medications include _____. _____ is not taking any current medications. There is a negative history of severe head injuries, seizure disorder, and major surgeries. Vision is normal. Hearing is normal. _____ has been in psychosocial therapy for _____. Previous neuropsychological testing has not been done.

Family:

_____ lives with _____.

Interpersonal:

Interpersonal relationships were described as satisfactory in both quality and quantity. _____ has manifested chronic difficulties establishing and maintaining interpersonal relationships of adequate intimacy.

Educational:

_____ has completed _____ years of formal education. High school graduation was in or about _____. Academic performance was typically _____. There was no grade retention. _____ received special education instruction and was classified as _____.

Vocational:

_____ is employed as a _____. _____ is a retired _____. _____ is unemployed. _____ has largely worked as a _____. Work history is _____.

Substance Abuse:

Unremarkable.

Legal:

Unremarkable.

Initial Assessment Summary:

Based upon the initial psychological assessment evidence, pre-test working diagnosis and disorders needed to be ruled out are listed below in the ensuing Pretest *DSM-IV-TR* Diagnosis section. The test data shall also provide answers to the additional referral questions listed above in the “Referral Information” section of this report. The test data shall also empirically measure the extent and severity of any neuropsychological deficits for purposes of treatment planning.

The following tests and estimated hours are requested:

1. Neuropsychological Assessment Battery, Form 1 (NAB) (7 hours)
2. Neuropsychological Assessment Screening Battery (NASB), Form 1 (2 hours)
3. Millon Clinical Multiaxial Inventory—III (MCMI—III) (1 hour)
4. Minnesota Multiphasic Personality Inventory—2—Restructured Form (MMPI—2—RF) (1 hour)
5. Minnesota Multiphasic Personality Inventory—2 (MMPI—2) (1 hour)
6. Rorschach Inkblot Test, Comprehensive System, RIAP Fifth Edition (Rorschach—CS) (2 hours)
7. Neuropsychological Assessment Battery (NAB), Attention Module Subtests, Form 2 (2 hours)
8. Conners’ Continuous Performance Test, Second Edition, Version 5 (CPT—II) (1 hour)
9. Conners’ Adult ADHD Rating Scales (CAARS —L), Self-Report and Observer Forms (1 hour)
10. Wechsler Adult Intelligence Scale, Fourth Edition (WAIS—IV) (3 hours)
11. Wechsler Memory Scale, Fourth Edition (WMS—IV), Form Ages 16 to 69 (3 hours)
12. Wechsler Memory Scale, Fourth Edition (WMS—IV), Form Ages 65 to 90 (3 hours)
13. Ability—Memory Discrepancy Analysis (1 hour)
14. Wechsler Individual Achievement Test, Third Edition, K—12 (WIAT—III, K—12) (3 hours)

15. Ability–Achievement Discrepancy Analysis (1 hour)
 16. Vineland Adaptive Behavior Scales, Second Edition (Vineland–II) (2 hours)

One (1) additional hour is requested for data integration and report composition. Total requested neuropsychological testing hours is (Billing Code 96118). Psychological testing hours is (Billing Code 96101).

Finally, one (1) individual hour (Billing Code 90806) is requested for a follow-up test feedback session and treatment planning.

All of the above-enumerated tests have sufficient empirically derived reliability and validity, and are age-appropriate. Furthermore, these tests are the most recently published editions.

The above-enumerated test has sufficient empirically derived reliability and validity, and is age-appropriate. Furthermore, this test is in its most recently published edition.

Pretest DSM-IV-TR Diagnoses:

Axis I:

- 296.90 Mood Disorder NOS
- 311 Depressive Disorder NOS
- 296.80 Bipolar Disorder NOS
- 300.00 Anxiety Disorder NOS
- 298.9 Psychotic Disorder NOS
- 294.9 Cognitive Disorder NOS
- 309.0 Adjustment Disorder With Depressed Mood
- 309.24 Adjustment Disorder With Anxiety
- 309.28 Adjustment Disorder With Mixed Anxiety and Depressed Mood
- 309.3 Adjustment Disorder With Disturbance of Conduct
- 309.4 Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
- 309.9 Adjustment Disorder, Unspecified

Provisional, Rule Out:

- 300.4 Dysthymic Disorder, Early/Late Onset
- 296.22 Major Depressive Disorder, Single Episode, Moderate
- 296.32 Major Depressive Disorder, Recurrent, Moderate
- 296.34 Major Depressive Disorder, Recurrent, Severe With Psychotic Features
- 301.13 Cyclothymic Disorder
- 296.64 Bipolar I Disorder, Mixed, Severe With Psychotic Features
- 296.62 Bipolar I Disorder, Mixed, Moderate
- 296.89 Bipolar II Disorder
- 300.02 Generalized Anxiety Disorder
- 309.81 Posttraumatic Stress Disorder, Chronic
- 300.3 Obsessive-Compulsive Disorder
- 295.30 Schizophrenia, Paranoid Type
- 295.10 Schizophrenia, Disorganized Type
- 295.20 Schizophrenia, Undifferentiated Type
- 295.70 Schizoaffective Disorder, Bipolar Type/Depressive Type
- 293.81 Psychotic Disorder Due to a General Medical Condition, With Delusions
- 293.82 Psychotic Disorder Due to a General Medical Condition, With Hallucinations
- 290.40 Vascular Dementia, Uncomplicated, With Behavioral Disturbance
- 290.41 Vascular Dementia, With Delirium
- 290.42 Vascular Dementia, With Delusions

- 290.43 Vascular Dementia, With Depressed Mood
- 294.10 Dementia Due to Head Trauma, Without Behavioral Disturbance
- 294.11 Dementia Due to Head Trauma, With Behavioral Disturbance
- 294.10 Dementia of the Alzheimer's Type, With Late Early Onset, Without Behavioral Disturbance
- 294.11 Dementia of the Alzheimer's Type, With Late Early Onset, With Behavioral Disturbance
- 294.10 Dementia Due to . . . [A General Medical Condition, Parkinson's Disease, Huntington's Disease, Multiple Etiologies], Without Behavioral Disturbance
- 294.11 Dementia Due to . . . [A General Medical Condition, Parkinson's Disease, Huntington's Disease, Multiple Etiologies], With Behavioral Disturbance
- 294.8 Dementia Due to Unknown Etiology
- 294.10 Substance-Induced Persisting Dementia, Without Behavioral Disturbance
- 294.11 Substance-Induced Persisting Dementia, With Behavioral Disturbance
- 291.2 Alcohol-Induced Persisting Dementia
- 293.83 Mood Disorder Due to Alzheimer's Disease, With Depressive Features
- 294.0 Amnesic Disorder Due to . . . , Transient/Chronic
- 292.83 Substance-Induced Persisting Amnesic Disorder
- 294.9 Mild/Moderate Neurocognitive Disorder (Cognitive Disorder NOS)
- 293.83 Mood Disorder Due to a General Medical Condition
- 310.1 Personality Change Due to a General Medical Condition
- 314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type
- 314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
- 314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
- 299.00 Autistic Disorder
- 299.80 Asperger's Disorder
- 299.80 Pervasive Developmental Disorder NOS (Atypical Autistic Disorder)
- 315.00 Reading Disorder
- 315.01 Mathematics Disorder
- 315.2 Disorder of Written Expression

Axis II:

- V71.09 No Diagnosis
- 799.9 Diagnosis Deferred

Rule Out:

- 301.83 Borderline Personality Disorder
- 301.81 Narcissistic Personality Disorder
- 301.7 Antisocial Personality Disorder
- 301.50 Histrionic Personality Disorder
- 301.82 Avoidant Personality Disorder
- 301.6 Dependent Personality Disorder
- 301.4 Obsessive-Compulsive Personality Disorder
- 301.20 Schizoid Personality Disorder
- 301.22 Schizotypal Personality Disorder
- 301.0 Paranoid Personality Disorder
- 317 Mild Mental Retardation
- 318.0 Moderate Mental Retardation

Axis III:

- No Contributory or Pertinent Medical Disorders Noted
- History of Traumatic Brain Injury (TBI)
- 435.9 Ischemic Attack, Transient (TIA)
- 436 Stroke (Cerebrovascular Accident)
- 332.0 Parkinson's Disease, Primary
- 331.0 Alzheimer's Disease
- 401.9 Hypertension, Essential
- 250.00 Diabetes Mellitus, Type II
- 850.9 Concussion
- 345.10 Epilepsy, Grand Mal
- 345.00 Epilepsy, Petit Mal
- 428.0 Failure, Congestive Heart
- 070.51 Hepatitis, Viral C

Axis IV:

- Psychosocial Stressors – Social, Occupational, Medical, Primary Support Group, Educational

Axis V:

- Global Assessment of Functioning (GAF): 45 Serious Moderate symptoms
- Prognosis: Deferred pending neuropsychological assessment and test results

Psychologist Name, PhD, PsyD, HSPP
Psychologist – State License # _____

FORM 2.4**MMSE-2 BRIEF VERSION TABULAR TEMPLATE WITH STANDARD MENTAL STATUS INFORMATION**

Mental Status Examination Including the Mini-Mental State Examination, Second Edition, Brief Version, Blue Form (MMSE-2-BV-BF): Affect was _____. Mood was _____. Thought process was logical, sequential, relevant, and coherent. Thought content was reality-based and normal. The MMSE-2-BV-BF results were as follows:

TABLE 1 ■ MMSE-2-BV-BF RESULTS

Cognitive function	Patient's raw score	Maximum possible raw score
Registration	3	3
Orientation to Time	5	5
Orientation to Place	5	5
Recall	3	3
Total Raw Score^a	16	16

Note: Lower raw scores indicate greater neurocognitive dysfunction. Overall neurocognitive function data are in boldface.

^aRaw scores of 14 or less indicate the need for more comprehensive neuropsychological testing.^b

^bUsing this cutoff, there is 97% confidence that a true case of neuropsychological disorder is recommended for further testing.

Screening result: Negative–positive for neuropsychological disorder.

Immediate, intermediate, and long-term memory functions were normal and intact. _____ was oriented to time, place, and person. Estimated intellectual function based on verbal skills, fund of general knowledge, and abstract reasoning abilities is average. Psychotic symptoms were not evident. There was no evidence of suicidal thoughts, intentions, or plans. There was no evidence of self-mutilation or self-harm.

FORM 2.5**MMSE-2 STANDARD VERSION TABULAR TEMPLATE WITH STANDARD MENTAL STATUS INFORMATION**

Mental Status Examination Including the Mini-Mental State Examination, Second Edition, Standard Version, Blue Form (MMSE-2-SV-BF): Affect was _____. Mood was _____. Thought process was logical, sequential, relevant, and coherent. Thought content was reality-based and normal. The MMSE-2-SV-BF results were as follows:

TABLE 1 ■ MMSE-2-SV-BF RESULTS

Cognitive function	Patient's raw score	Maximum possible raw score
Registration	3	3
Orientation to Time	5	5
Orientation to Place	5	5
Recall	3	3
Attention and Calculation	5	5
Naming	2	2
Repetition	1	1
Comprehension	3	3
Reading	1	1
Writing	1	1
Drawing	1	1
Total Raw Score^a	30	30

Note: Lower raw scores indicate greater neurocognitive dysfunction. Overall neurocognitive function data are in boldface.

^aRaw scores of 27 or less indicate the need for more comprehensive neuropsychological testing.^b

^bUsing this cutoff, there is 97% confidence that a true case of neuropsychological disorder is recommended for further testing.

Screening result: Negative–positive for neuropsychological disorder.

Immediate, intermediate, and long-term memory functions were normal and intact. _____ was oriented to time, place, and person. Estimated intellectual function based on verbal skills, fund of general knowledge, and abstract reasoning abilities is average. Psychotic symptoms were not evident. There was no evidence of suicidal thoughts, intentions, or plans. There was no evidence of self-mutilation or self-harm.

FORM 2.6**MMSE-2 EXPANDED VERSION TABULAR TEMPLATE WITH STANDARD MENTAL STATUS INFORMATION**

Mental Status Examination Including the Mini-Mental State Examination, Second Edition, Expanded Version, Blue Form (MMSE-2-EV-BF): Affect was. Mood was. Thought process was logical, sequential, relevant, and coherent. Thought content was reality-based and normal. The MMSE-2-EV-BF results were as follows:

TABLE 1 ■ MMSE-2-EV-BF RESULTS

Cognitive function	Patient's raw score	Maximum possible raw score
Registration	3	3
Orientation to Time	5	5
Orientation to Place	5	5
Recall	3	3
Attention and Calculation	5	5
Naming	2	2
Repetition	1	1
Comprehension	3	3
Reading	1	1
Writing	1	1
Drawing	1	1
Story Memory	25	25
Processing Speed	35	35
Total Raw Score^a	90	90

Note: Lower raw scores indicate greater neurocognitive dysfunction. Overall neurocognitive function data are in boldface.

^aRaw scores of 50 or less indicate the need for more comprehensive neuropsychological testing.^b

^bUsing this cutoff, there is 97% confidence that a true case of neuropsychological disorder is recommended for further testing.

Screening result: Negative–positive for neuropsychological disorder.

Immediate, intermediate, and long-term memory functions were normal and intact. _____ was oriented to time, place, and person. Estimated intellectual function based on verbal skills, fund of general knowledge, and abstract reasoning abilities is average. Psychotic symptoms were not evident. There was no evidence of suicidal thoughts, intentions, or plans. There was no evidence of self-mutilation or self-harm.

FORM 2.7

NAME OF PRACTICE PSYCHOLOGICAL TEST LISTING FORM

Intelligence Tests

Wechsler Preschool and Primary Scale of Intelligence, Third Edition (WPPSI–III)
(ages 2:6 to 7:3)

Wechsler Intelligence Scale for Children, Fourth Edition (WISC–IV) (ages 6:0 to 16:11)

Wechsler Adult Intelligence Scale, Fourth Edition (WAIS–IV) (ages 16:0 to 90:11)

Achievement Tests

Wechsler Individual Achievement Test, Third Edition (WIAT–III) (ages 4:0 to 50:11)

Neuropsychological Tests

NEPSY–II, Form Ages 3 to 4 (ages 3:0 to 4:11)

NEPSY–II, Form Ages 5 to 16 (ages 5:0 to 16:11)

Neuropsychological Assessment Battery (NAB), Form 1 or 2 (ages 18:0 to 97:11)

Neuropsychological Assessment Screening Battery (NASB), Form 1 or 2 (ages 18:0 to 97:11)

Wechsler Memory Scale, Fourth Edition (WMS–IV) (ages 16:0 to 90:11)

Conners' Kiddie Continuous Performance Test, Version 5 (K–CPT) (ages 4:0 to 5:11)

Conners' Continuous Performance Test, Second Edition, Version 5 (CPT–II)
(ages 6:0 to 55:0 and older)

Symptom Rating Scales

Conners Early Childhood (Conners EC), Parent and Teacher/Childcare Forms
(ages 2:0 to 5:11)

Conners Comprehensive Behavior Rating Scales (Conners CBRS), Parent and Teacher
Forms (ages 6:0 to 18:11), and Self-Report Form (ages 8:0 to 18:11)

Gilliam Autism Rating Scale, Second Edition (GARS–2) (ages 3:0 to 22:11)

Gilliam Asperger's Disorder Scale (GADS) (ages 3:0 to 22:11)

Conners' Adult ADHD Rating Scales, Long Version (CAARS–L), Self-Report and
Observer Forms (ages 18:0 to 50:0 and older)

Self-Report Clinical and Personality Inventories

Millon Pre-Adolescent Clinical Inventory (M–PACI) (ages 9:0 to 12:11)

Millon Adolescent Clinical Inventory (MACI) (ages 13:0 to 19:11)

Millon Clinical Multiaxial Inventory–III (MCMI–III) (ages 18:0 to 88:11)

Minnesota Multiphasic Personality Inventory– Adolescent (MMPI–A) (ages 14:0 to 18:11)

Minnesota Multiphasic Personality Inventory–2–Restructured Form (MMPI–2–RF)
(ages 18:0 to 89:11)

Examiner Administered Personality Tests

Rorschach Inkblot Test, Comprehensive System, RIAP Fifth Edition (Rorschach–CS)
(ages 5:0 to 86:0)

Roberts–2 (ages 6:0 to 18:11)

Adaptive Behavior Tests

Vineland Adaptive Behavior Scales, Second Edition (Vineland–II) (ages 0:1 to 90:11)

FORM 2.8**NAME OF PRACTICE
PATIENT TEST INSTRUCTION FORM****Patient Name:** _____**Account Number:** _____

1. This completed initial psychological assessment will be submitted to your health insurance company for precertification of the ordered tests reviewed with you by the psychologist.
2. A maximum of _____ test hours are being requested, including administration, scoring, interpreting, and integrating the data, and composing the final comprehensive report.
3. Once precertification has been obtained, we shall contact you to schedule the following appointment(s) with the psychologist for purposes of test administration: _____
4. Prior to, or at the time of the scheduled test administration appointment(s), please return any symptom rating scales given to you by the psychologist at the time of the initial psychological assessment. They may be returned in person or by mail to:

Name of Psychologist, PhD, HSPP _____

Name of Practice: _____

Street Address: _____

City, State: _____

Please ensure that these rating scales are fully and properly completed, and that they are carefully secured by you until the time you submit them to the psychologist. They are critical for purposes of accurate diagnosis and properly addressing any related referral questions.

5. Once we notify you of test approval, you may come to the office any time during regular business hours (9:00 a.m. – 4:00 p.m.) to complete the following self-administered computer tests: _____

We suggest that you call our office first to determine availability of the testing computer. Upon your arrival, submit this form to the front desk staff for assistance.

6. Upon completion of the test administration process, the tests will be scored, interpreted, and presented within a final Psychological Evaluation Report including diagnoses, answers to any related referral questions, and treatment recommendations. A final appointment with the psychologist is advised for purposes of reviewing the test results and addressing any questions.
7. Reports may be released to the referral source(s) or relevant third parties by completing an “Authorization for Disclosure of Protected Health Information” form. Front desk staff will assist you in this regard.

FORM 2.9

**NAME OF PRACTICE
PSYCHOLOGICAL TEST REQUEST AND LOG FORM**

Identifying Information:

Patient Name

Last: _____ First: _____

Account Number: _____

Contact

Name: _____ Relationship to Patient: _____

Phone Number: _____

Test administration appointments to be scheduled with psychologist (number and duration): _____

Remind patient to independently complete the following self-administered test(s):

Hours Requested:	Date	Psychological Service
------------------	------	-----------------------

Psychological Test Hours: _____	_____	_____
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Neuropsychological Test Hours: _____	_____	_____
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Hours Approved:		
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Psychological Test Hours: _____	_____	_____
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Neuropsychological Test Hours: _____	_____	_____
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Insurance Authorization: (mark one)

_____ Required – From: _____ To: _____; _____ Not Required

_____ Self-Pay – Negotiated Fee: _____

Additional Information: _____
