Sara E. Wright, Ph.D.
Wright & Wright, PhD, LLC

16100 Chesterfield Parkway West, Suite 318
Chesterfield, MO 63017
Telephone (314) 991-1095
Fax (314) 991-1098

Registration Information

Name of Child:_____

Age:_____ Gender: M F Date of Birth:_____

Child's Address:_____

_____

Is this child represented by an attorney regarding matters related to this evaluation: Y N

Legal Custodian/s of Child: _____

Parent/Guardian #1:

Name:_____

Employer:_____

Work Phone:_____

Home Address:_____

_____

Telephone: _____ Email :_____

Parent/Guardian #2:

Name:_____

Employer:_____

Work Phone:_____

Home Address:_____

_____

Telephone: _____ Email :_____

I authorize Sara E. Wright, Ph.D. to communicate with the individual that referred me to her. She may speak with them about my diagnosis and treatment. Should I require a referral to another provider, I authorize Dr. Wright to communicate with that provider to ensure an appropriate referral.

_____ _____

Signature of Responsible Party **Date**

I request care for my child (or for myself if not a minor) from Sara E. Wright, Ph.D., for the purpose of a neuropsychological evaluation. The evaluation may include a clinical interview, record review, and neuropsychological testing. The neuropsychological testing may include measures of intellectual functioning, memory, attention, problem solving, language, visuospatial skills, motor functions, motivation, and academic achievement, in addition to emotional and personality functioning. I may request further information about any of these procedures. I agree to this care.

_____ _____

Signature of Responsible Party **Date**