Advanced Cognitive Health

Evaluation & Consultation Referral Request Form

Thank you for your referral to Advanced Cognitive Health. This form is designed to help us understand the requested service, referral question, relevant case information, and scheduling needs. Submission of this form does not establish a professional relationship or guarantee acceptance of a referral. Services are accepted based on clinician qualifications, jurisdiction, availability, conflicts, and the specific referral question.

REFERRING PARTY INFORMATION

Name: _____
Law Firm / Practice / Organization: _____
Professional Title: _____
Phone: _____
Email: _____
Preferred Method of Contact: ☐ Phone ☐ Email

CLIENT / EXAMINEE INFORMATION

Full Name: _____
Date of Birth: _____
Phone: _____
Email: _____
Preferred Language: _____
Interpreter Needed? ☐ Yes ☐ No ☐ Unknown
Parent/Guardian, if applicable: _____

REQUESTED SERVICE

A. FORENSIC & COURT-RELATED EVALUATIONS

☐ Immigration Evaluation
- ☐ Asylum
- ☐ VAWA
- ☐ U Visa
- ☐ T Visa
- ☐ Extreme Hardship
- ☐ Cancellation of Removal
- ☐ N-648
- ☐ Other Immigration Matter: _____

☐ Criminal Mitigation Evaluation

- ☐ Sentencing / Resentencing
- ☐ Bond / Pretrial
- ☐ Probation Violation
- ☐ Diversion
- ☐ Juvenile Transfer / Adult-Court Mitigation
- ☐ Reentry / Reintegration
- ☐ Other Mitigation Matter: _____

☐ Court-Related Substance Use Evaluation
- ☐ DUI / DWI
- ☐ Drug-Related Case
- ☐ Probation / Community Supervision
- ☐ Diversion / Problem-Solving Court
- ☐ Substance Use Disorder / Co-Occurring Evaluation
- ☐ Treatment Needs / Level of Care
- ☐ Relapse / Recurrence Risk
- ☐ Rehabilitation / Progress
- ☐ Other Substance-Related Matter: _____

☐ Trauma & Emotional Damages Evaluation
- ☐ Personal Injury
- ☐ Employment-Related Matter
- ☐ Civil Rights Matter
- ☐ Crime-Victim Matter
- ☐ Emotional Distress / Psychological Injury
- ☐ Other Trauma / Damages Matter: _____

B. DIAGNOSTIC & CLINICAL EVALUATIONS

☐ Comprehensive Diagnostic Evaluation
☐ Diagnostic Clarification / Differential Diagnosis
☐ Depression / Mood Disorder Evaluation
☐ Anxiety Disorder Evaluation
☐ Trauma / PTSD Evaluation
☐ Substance Use Disorder Evaluation
☐ Co-Occurring Mental Health & Substance Use Evaluation
☐ Behavioral & Functional Assessment
☐ Treatment Needs / Level-of-Care Assessment
☐ Pre-Surgical Behavioral Health Evaluation
☐ Other: _____

C. CONSULTATION / OTHER REQUESTED SERVICES

☐ Professional Consultation

☐ Attorney / Forensic Case Consultation
☐ Behavioral Health Record Review
☐ Expert Consultation / Testimony
☐ Psychotherapy Referral
☐ Other: _____

REFERRAL QUESTION / PURPOSE OF EVALUATION

Please describe the specific question(s), issue(s), or purpose you would like the evaluator or consultant to address. For legal matters, please identify the relevant psycholegal question as specifically as possible.

_____
_____
_____
_____

CASE INFORMATION — IF APPLICABLE

Case Name / Style: _____
Case / Cause Number: _____
Court / Jurisdiction: _____
Referring / Retaining Attorney: _____
Opposing Counsel, if applicable: _____
Upcoming Hearing / Trial / Deadline: _____
Requested Report Due Date: _____

Is the matter currently in litigation? ☐ Yes ☐ No ☐ Unknown
Has an evaluation already been completed by another professional? ☐ Yes ☐ No ☐ Unknown

If yes, please identify the evaluator or report, if known:
_____

RECORDS & SUPPORTING INFORMATION

Please indicate records that are available or may be provided for review:

☐ Court orders / pleadings / legal documents
☐ Immigration documents
☐ Medical records
☐ Mental health treatment records
☐ Substance use evaluation / treatment records
☐ Previous behavioral health or psychological evaluations

☐ Medication records
☐ Probation / community-supervision records
☐ Employment records
☐ Educational records
☐ Police / incident reports, when relevant and appropriate
☐ Other: _____

Please briefly identify any particularly important records or information:
_____
_____

COLLATERAL INFORMATION

Are there individuals or professionals who may have relevant collateral information? ☐ Yes ☐ No ☐ Unknown

If yes, please identify, if known:
Name / Role: _____
Name / Role: _____
Name / Role: _____

The evaluator will determine whether collateral information is appropriate and what authorizations may be required.

REPORT & COMMUNICATION INFORMATION

Is a written report requested? ☐ Yes ☐ No ☐ To Be Determined

Preferred / Authorized Report Recipient(s):
_____

Is consultation regarding findings requested? ☐ Yes ☐ No ☐ To Be Determined

Is deposition, hearing, or trial testimony anticipated? ☐ Yes ☐ No ☐ Unknown

If yes, anticipated date, if known: _____

SCHEDULING & URGENCY

Requested timeframe for evaluation / consultation: _____
Known court, filing, or case deadline: _____

Is expedited service being requested? ☐ Yes ☐ No

Additional scheduling information:
_____

ADDITIONAL INFORMATION

Please provide any additional information that may help us determine whether the referral can be accepted and appropriately assigned:

_____
_____
_____

REFERRING PARTY ACKNOWLEDGMENT

I understand that submission of this referral request does not establish an evaluator-client, treatment, consultation, or expert-witness relationship. Advanced Cognitive Health will review the referral for scope, clinician qualifications, jurisdictional requirements, conflicts, availability, and other relevant considerations before confirming acceptance.

Referring Party Name: _____
Signature, if applicable: _____
Date: _____

Advanced Cognitive Health
Forensic & Court-Related Behavioral Health Evaluations | Diagnostic & Clinical Evaluations | Professional Consultation

Services are provided only by professionals whose licensure, training, experience, and jurisdictional authority permit the requested service.