DATE OF REFERRAL: _____

EXPERT:
☐ JS ☐ NT ☐ DC
☐ OTHER _____

APPT. DATE: _____ Associate: _____

FORENSIC CASE REFERRAL FORM

Case Type: ☐PLN ☐DEF ☐PVT ☐OTH _____

Responsible Law Firm: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Billing Contact: _____ Billing Email: _____

Lead Attorney Name (s): _____ Direct Line: _____

Paralegal/ Secretary: _____ Email: _____

Co-Counsel: _____

Case Number_____ Case Filing: County of _____

Patient Name: _____ **DOB**: _____ **Age**: _____

Gender: ☐M ☐F **Marital Status**: ☐S ☐M ☐DIV ☐W **Years Education**: _____

Primary Language _____ **Secondary Language**: _____ **Interpreter**: ☐Y ☐N

Employed: ☐Y ☐N _____

DOI: _____ **Trial Date/ Other Deadlines**: _____

Cause of Injury: _____

Length of Initial Hospitalization: _____**Where**: _____

Previous Neuropsych Evals (when/by whom): _____

Current Medication: _____

Coronavirus Exposure: ☐Y ☐N COVID-19 Symptoms: ☐Y ☐N

Brief Case Synopsis of Symptoms:

_____

_____

_____