DATE OF REFERRAL: _____

EXPERT:
☐ JS ☐ CS ☐ 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: _____

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

Gender: M / F **Marital Status**: S M DIV W **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: _____

Brief Case Synopsis:

_____

_____

_____

_____