

PROFESSIONAL REFERRAL FORM

REFERRING PROVIDER

Provider / Organization Name

Phone

Address

Contact Person

Email

City, State, Zip

Provider Type:

Special Education Attorney

School Psychologist / Learning Specialist

Psychiatrist / Therapist

Educational Consultant

Pediatrician / Dev. Pediatrician

Other

CLIENT / PATIENT INFORMATION

Client Name (Last, First)

Date of Birth

Age

Grade / Level

School / Employer

Parent / Guardian Name (if minor)

Relationship

Client / Guardian Phone

Client / Guardian Email

REFERRAL DETAILS

Urgency:

Routine (4-6 wks)

Expedited (2-3 wks)

Urgent -- Legal Deadline

Legal / Hearing Deadline

Case / File Number

Primary Referral Question / Reason for Referral:

Services / Evaluation Type Requested:

Comprehensive Neuropsychological Evaluation

Autism Spectrum Disorder (ASD) Evaluation

Independent Educational Evaluation (IEE - NYC DOE)

Professional Exam Accommodations (LSAT/Bar/MCAT/GRE/GMAT)

Twice-Exceptional (2e) Evaluation

ADHD Evaluation

Learning Disability Evaluation

Due Process / Expert Witness Support

OPWDD / Intellectual Disability Evaluation

Other

EXISTING DOCUMENTATION (attach if available)

Prior neuropsychological / psychoeducational evaluation

School records / progress reports

Prior hearing officer decisions

Other

IEP / 504 Plan

Medical / psychiatric records

Attorney correspondence

ADDITIONAL NOTES / CLINICAL CONTEXT

Additional context that would help us prepare:

REPORT SHARING

With the client's written authorization, we are happy to share findings with referring providers.

Please send me a copy of the completed report

No copy needed -- refer family back to me after evaluation

I am legal counsel on an active case -- please coordinate directly with me