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INFORMED CONSENT FOR ATTORNEY-REFERRED INDEPENDENT NEUROPSYCHOLOGICAL ASSESSMENT

Consent and Release of Neuropsychological Testing Results

Name: _____ Date: _____

I have been retained by the law firm or insurance company of _____ to conduct a neuropsychological evaluation. Neuropsychological evaluation is used to measure how well different parts of the brain work. This examination involves performing tests of attention, memory, speech, language, and problem-solving skills. You will be asked about your current medical symptoms. In addition, you will be asked to fill out questionnaires regarding your past moods and behavior, as well as developmental, behavioral, educational, and medical history. You may be asked to sign release forms to allow me to interview other family members, teachers, physicians, or anyone thought to be a reliable informant regarding your history and/or current behavior. You will be asked to sign release forms to allow us to obtain all relevant medical and school records.

It is important that you be as honest as possible when answering the questions. Information that is incomplete or misleading may be damaging to your case. It is important for us to discuss any concerns you have.

Results of neuropsychological testing are ordinarily confidential and can be released only following a written consent authorizing their release. However, when neuropsychological testing is performed for use in legal cases, results are provided to the attorney requesting the assessment and are subsequently made available to the opposing law firm after the appropriate paperwork has been executed.

Please initial each item below to indicate that you have carefully read and understand each one:

_____I understand that Stephanie Moore, PsyD has been hired by _____ to conduct a neuropsychological assessment.

_____I understand that the battery of neuropsychological tests may take 4 to 8 hours, but additional time may be required.

_____I understand that Stephanie Moore, PsyD will write a formal report about my case based on the results of the neuropsychological assessment.

_____I understand that a copy of the formal report will become part of the medical record.

_____I authorize Stephanie Moore, PsyD to send a copy of this formal report to the attorney requesting the evaluation and to discuss the report with the attorney or his/her representative.

_____I understand that Stephanie Moore, PsyD may be called to testify about me and/or my child and this assessment in depositions and trial(s) related to my legal case.

_____I understand that Stephanie Moore, PsyD will not provide me with results, recommendations, or treatment without my attorney's permission.

_____I understand that I will not be given a copy of the neuropsychological results without my attorney's permission ([45 CFR 45 164.508 and 164.524[(a])[(1)]).

If you have read, understood, and initialed each of the prior sections, please read carefully the following statement and sign.

Do *not* sign if you have any further questions or if there are any aspects that you do not understand or that you do not agree to. You may call your attorney at this time for guidance concerning how to proceed so that you fully understand the process and can decide whether you wish to continue.

Consent Agreement: I have read, agreed to, and initialed each of the previous sections. I have asked questions about any parts that I did not understand fully. I have also asked questions about any parts that I was concerned about. By voluntarily signing below, I indicate that I understand and agree to the nature and purpose of this testing, how it will be reported, and to each of the points listed above.

_____ _____

Signature Date

_____

Print Name

Name: _____ Date: _____

Address (Street, City, Zip): _____

Examinee's Telephone Number: (H):_____ W): _____

Guardian's Telephone Number: (H): _____ (W): _____

Age: _____ Date of Birth: _____ Sex: ____ Years of Education: _____

Place of Birth: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Ethnic/Racial Background: _____ Religion: _____

Vision Problems (double, blurred, loss, glasses): _____

Hearing Problems (tinnitus, hearing aid) _____

Name of Referring Physician, Friend: _____

Briefly describe your problem _____

_____

_____

What specific questions would you like answered by this evaluation?

1._____

2._____

3._____

This form has been completed by: _____

If not completed by the examinee, please provide the following information:

Name: _____ Relationship to Examinee: _____

Address: _____

Telephone Number: (H) _____ (W) _____

DEVELOPMENTAL HISTORY

4. You were born: on time ___ prematurely ___ late ___
5. Your weight at birth: ___ pounds ____ ounces

6. Mother's weight during pregnancy: ___ pounds

7. Were there any problems associated with your birth (such as oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (i.e., need for oxygen, special equipment used, convulsions, illness, etc.). Yes ___ No ___

8. Check all that applied to your mother while she was pregnant with you:

___ Accident
___ Alcohol use
___ Cigarette smoking
___ Drug use (marijuana, speed, cocaine, LSD, etc.).
___ Flu/Influenza
___ Illness (toxemia, diabetes, high blood pressure, infection, Rh incompatibility)
___ Poor nutrition
___ Psychological problems (depression, mania, Schizophrenia, etc.)
___ Other problems: _____

9. List all medications prescribed or over-the-counter that your mother took while pregnant with you: _____

10. During her pregnancy, did your mother live near a polluted area (toxic waste dump) or other hazardous area (nuclear plant, industrial area, pesticide sprayed area)?

11. Rate your developmental progress as it has been reported to you by checking one:

	Early	Average	On time
Walking			
Language			
Toilet Training			
Overall Development			

12. As a child did you have any of these conditions? If so, circle the condition.

Attention Problems	Head Injury	Muscle Tightness/weakness
Clumsiness	Hearing Problems	Speech Problems
Developmental Delay	Hyperactivity	Vision Problems
Frequent Ear Infections	Learning Disability	Loss of Consciousness

Other problems? _____

PAST MEDICAL HISTORY

13. Circle all conditions diagnosed when you were a **child** and indicate age, treatment provided and any other pertinent information:

Allergies	Epilepsy or Seizure	Pneumonia
Asthma	Fevers (104 F or higher)	Poisoning
Brain Infection/Disease	Heart Problems	Polio
Cancer	Immune System Disease	Rheumatic Fever
Cerebral Palsy	Kidney Problems	Scarlet Fever
Chicken Pox	Lung (respiratory) Disease	Tuberculosis
Colds (excessive)	Measles	Venereal Disease
Diabetes	Meningitis	Whooping Cough
Encephalitis	Oxygen Deprivation	
Other:		

14. As a child, were you exposed to excessive amounts of lead (e.g. Eating paint chips, living next to high concentrations of automobile exhaust fumes? Circle: Yes/No

If "yes" please explain: _____

15. As a child did you ever have an accident that required a hospital visit? Circle: Yes/No

If "yes" please describe: _____

16. List all medications that were regularly given to you as a child:

Medication	Reason for the Medication
_____	_____
_____	_____
_____	_____

CURRENT MEDICAL HISTORY

17. Circle all that currently apply

AIDS, ARC, HIV+	Heart disease	Parkinson's disease
Allergies	Huntington's disease	Polio
Arteriosclerosis	Hypertension	Psychiatric problems
Arthritis	Kidney disease	Radiation exposure
Blood disorder	Liver disease	Senility (dementia)
Brain disease/infection	Lung/respiratory disease	Stroke/ TIAs
Cancer or chemotherapy	Malnutrition	Thyroid disease
Diabetes	Meningitis	Venereal disease
Hazardous/Toxic exposure	Multiple sclerosis	Incontinence

Any other problems: _____

18. List all medications, over-the-counter drugs or herbs that you currently take, including the dosage and any side effects.

Please include both prescription and over-the-counter medications:

Medications	Dosage	Side-Effects

Do you take the medications as prescribed: circle YES or NO?

19. Do you have epilepsy or a seizure disorder: circle YES or NO

If "YES" circle the type with which you have been diagnosed:

PARTIAL	GENERALIZED	UNCLASSIFIED TYPE
Simple, partial (Jacksonian)	Absence (Petit Mal)	
Complex Partial (psychomotor)	Myoclonic	
Partial evolving into generalized	Clonic	
	Tonic-clonic (grand mal)	
	Atonic	

If you have seizures and do not know what type, please describe them: _____
_____

20. Have you ever experienced a head injury: circle YES or NO. Describe the circumstances and any problems you had afterwards: _____
_____

Were you in a coma? Circle *YES* or *NO*. How long: _____?

Last clear memory prior to injury: _____?

First continuous memory after injury _____?

21. Describe all hospitalizations you have had:

a. _____

b. _____

c. _____

FAMILY HISTORY

The following questions deal with your biological mother, father, brothers, sisters:
MOTHER

22. What is your mother's name (including maiden name) _____.

23. If she is alive, what is her present age: _____?

24. If deceased, her cause of death was: _____at age: _____?

25. Mother's level of education: _____?

26. Mother's occupation _____?

27. Does your mother have a known or suspected learning disability: circle YES or NO.

If yes, please describe: _____.

28. Describe your mother's health history _____

FATHER

29. What is your father's name _____?

30. If he is alive, what is his present age: _____? If deceased, his cause of death was: _____? At age: _____?

31. Father's occupation _____?

32. Father's level of education: _____?

33. Does your father have a known or suspected learning disability: circle YES or NO.

If yes, please describe: _____.

34. Describe your father's health history:
_____

35. What were the ages of your Mother: _____ Father: _____when you were born?

36. Who raised you: (Check all who apply and at what ages)

Biological parent (s)	Relatives	Foster parents
Biological and stepparent	Adoptive parents	Institution

Others:		

37. What languages were spoken at home: Primary: ____ Secondary: ____

SIBLINGS:

38. How many brothers _____ and sisters _____ do you have?

39. Where are you in the birth order?

40. Are there any unusual problems (physical, academic, psychological) associated with any of your siblings? Circle YES or NO. If "YES" please describe:
_____

41. Please check all that existed in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles).

	WHO	DESCRIBE
Epilepsy		
Learning Disability		
Left-handedness		
Mental Retardation		
Speech/Language Disorder		
Auto-immune Disorder		
Other major disease/disorder		
NEUROLOGIC DISEASE		
Alzheimer's disease/senility		
Huntington's disease		
Parkinson's disease		
Multiple Sclerosis		
ALS/ Lou Gehrig's Disease		
Down's Syndrome		
Other neurologic disease		
PSYCHIATRIC ILLNESS		
Alcoholism		
Manic Depressive/Bipolar		
Depression		
Personality disorder		
Schizophrenic		
Criminal/Violent Behavior		
Other psychological Illness		

PERSONAL HISTORY
Marital History:

42. Current status: Married___ Single ___ Divorced___ Widowed ____ Separated ____
43. Years married to current spouse: _____ 45. Number of times married: _____

44. If married, spouse's name: _____ Spouse's age: _____
45. Spouse's occupation: _____

46. Spouse's health: Excellent ____ Good ____ Poor ____

47. Not married, but living with someone: Yes ____ No ____

His/her health: Excellent ____ Good ____ Poor ____
His/her occupation: _____

48. Names and ages of children:

Educational History:

49. Highest grade completed or highest degree earned: _____
Name of school and country in which education was received: _____

50. How would you describe your usual performance as a student?

A & B	*Please describe any helpful information*:
B & C	
C & D	
D & F	

51. Did you ever repeat a grade? Circle YES or NO. If "YES" what grade and for what reason? _____

52. Were you ever in any special classes or receive special services: YES or NO
IF "YES" what grade ____ or age: ____ and what type of service: _____?

53. Were you ever suspended or expelled from school: YES or NO. If so, please explain:
_____

Occupational History

54. Current job title:

55. Salary: under $10,000___ $10,000-29,999___, $30,000-50,000___, over $50,000___
56. How long have you been at this job? _____
57. Current job responsibilities _____

58. List prior jobs, starting with the most recent:

POSITION	*LENGTH OF TIME ON THIS JOB*

59. At any time while on the job, were you exposed to hazardous or noxious substances (e.g., lead, mercury, asbestos, radiation, solvents, pesticides, chemicals)? YES or NO. If "YES" please explain: _____

Military History

60. Branch: _____ Discharge rank: _____Type of discharge: _____

61. Major military duties: _____

62. List any physical injuries you had during military service: _____

63. Were you exposed to any dangerous substances while in the military (e.g., Agent Orange, radiation, etc.)? Explain: _____

Recreation

64. List the types of recreation that you enjoy (i.e., sports, games, TV, hobbies, etc.): _____

Substance use history
<u>Alcohol</u>

65. I started drinking at age: _____

66. I drink alcohol: Rarely/never ____ 1-2 days/week ____ 3-5 days/week ___ Daily ___

67. I used to drink but stopped on: date stopped _____

68. Preferred type (s) of drinks: _____

69. Usual number of drinks I have at a time: _____

70. My last drink was less than 24 hours ago ___ 24-48 hours ___ over 48 hours ____

71. Check all that apply:
___ I can drink more than most people at my age and size before I get drunk.
___ I sometimes get into trouble (fights, legal difficulties, problems at work, conflicts with family, accidents, etc.) after drinking.
___ I sometimes black out after drinking.
___ I sometimes drink in the morning.
___ I have had a DUI

Cigarettes
72. I started smoking at age: _____ Stopped at age: _____

73. I currently smoke _____ cigarettes each day.

Drugs
74. Please check all the drugs you are currently using or have used in the past:

	FROM	AMOUNTS CONSUMED	FREQUENCY
Amphetamines			
Barbiturates			
Cocaine/Crack			
Hallucinogens			
Inhalants			
Marijuana			
Opiates			
PCP			

Please list all other drugs used: _____

75. Do you consider yourself dependent on any of the above drugs: YES or NO

76. Do you consider yourself dependent on any prescription drugs? YES or NO. Which prescription drugs: _____

77. Check all that apply:
____ I have gone through drug withdrawal
____ I have used I.V. drugs
____ I have been in drug treatment. Year: _____ Where: _____

Legal and Suicide History

78. Legal difficulties: (i.e., arrests, restraining orders, property damage, law suits, DUIs, etc.): _____

79. History of suicidal behavior: *YES* or *NO*
Suicide attempts: When _____ Describe _____
Suicidal Ideation/threat: When _____ Describe _____

Do you have suicidal thoughts now? *YES* or *NO*

80. Have you ever physically assaulted another person *YES* or *NO*. If "*YES*" please describe: _____
81. Please list any recent stressors you have experienced (i.e., death of a loved one, divorce, unemployment, pregnancy, retirement, change of residence, etc.) _____
_____

Medical Testing

82. Check all the medical tests that have recently been completed and state any abnormal results:

TEST	ABNORMAL FINDINGS
Angiography	
Blood work	
Brain scan	
CT scan	
EEG	
Lumbar puncture/spinal tap	
MRI	
Neurological office exam	
PET scan	
Physician's office exam	
Skull x-ray	
Ultrasound	
Other testing results:	

83. Identify the physician who is most familiar with your recent problems:
Name: _____
Address; _____
Telephone: _____
Date of your last medical check-up: _____
Findings at check-up: _____

84. Have you had a prior psychological or neuropsychological evaluation YES or NO
Name of psychologist: _____
Address; _____
Telephone: _____
Date and reason for evaluation: _____
Findings of evaluation: _____

85. Have you had psychological treatment YES or NO? If "YES"
Name of therapist: _____
Address; _____
Telephone: _____
Dates of treatment and reason for evaluation: _____

REVIEW OF SYSTEMS

Constitutional Symptoms
- ☐ Good General Health today
- ☐ Recent Weight Change
- ☐ Fever/Chills
- ☐ Fatigue
- ☐ Fever

Eyes
- ☐ Eye Disease/Injury/Blindness
- ☐ Wear Glasses/Contact Lenses
- ☐ Blurred, Dizziness or Double Vision
- ☐ Glaucoma

Ears, Nose, Mouth, Throat
- ☐ Hearing Tones or Ringing
- ☐ Hearing Loss
- ☐ Chronic sinus problem or tinnitus
- ☐ Nose bleeds
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath or Bad Taste
- ☐ Voice Change
- ☐ Swollen neck glands

Cardiovascular
- ☐ Heart Trouble
- ☐ Chest pain or Angina Pectoris
- ☐ Palpitations
- ☐ Shortness of Breath w/ walking/lying flat
- ☐ Swelling of Feet or Ankles

Respiratory
- ☐ Chronic or Frequent Coughs
- ☐ Spitting up Blood
- ☐ Shortness of Breath
- ☐ Asthma or Wheezing

Gastrointestinal
- ☐ Loss of Appetite
- ☐ Change in Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Reflux disease
- ☐ Constipation
- ☐ Bleeding or Blood in Stool
- ☐ Abnormal Pain or Heartburn
- ☐ Peptic Ulcer (stomach or duodenal)

Genitourinary
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Sexual Difficulties
- ☐ Pregnancy Difficulties
- ☐ Irregular Periods

Thank you for filling out this lengthy form

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Stiffness or Swelling
- ☐ Weakness of Muscles or Joints
- ☐ Muscle Pain or Cramps
- ☐ Back Pain
- ☐ Cold Extremities
- ☐ Difficulty Walking

Skin
- ☐ Rash or Itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose Veins
- ☐ Breast Pain or Lump
- ☐ Breast Discharge

Neurological
- ☐ Problems with Sleep
- ☐ Frequent or Recurring Headaches or Migraines
- ☐ Light-headed or dizzy
- ☐ Convulsions or Seizures
- ☐ Numbness or tingling sensation (arms/legs/face)
- ☐ Tremors
- ☐ Paralysis
- ☐ Stroke, Meningitis, Encephalitis, Seizure
- ☐ Head Injury
- ☐ Frequent Falls
- ☐ Chronic Fatigue

Psychiatric
- ☐ Nervousness
- ☐ Depression, Nervous Breakdown
- ☐ Insomnia
- ☐ Word-Finding Difficulty
- ☐ Problems with Attention/Concentration
- ☐ Memory Loss or Confusion

Endocrine
- ☐ Heat or Cold Intolerance
- ☐ Skin Becoming Drier
- ☐ Change in Hat or Glove Size
- ☐ Glandular or Hormonal Problems
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Excessive Thirst or Urination

Hematological/Lymphatic
- ☐ Slow to Heal Cuts
- ☐ Anemia
- ☐ Phlebitis
- ☐ Blood Transfusion
- ☐ Enlarged Glands
- ☐ Tendency to Bleed or Bruise Easily