Request for Dr. Simpson's Forensic Psychology Services

Your name:	Agency:
Address:	Office phone:
	Alt. phone:
	FAX:
	Email:
	Other:

Support staff:	Their phone:
	Their email:

If your client is out-of-custody, please provide any contact information you might have.

Client name:	Primary phone:
Address:	Alt. phone:
	FAX:
	Email:
	Other:

Who does our office send the bill to?

Name:	Agency:
Address:	Office phone:
	Alt. phone:
	FAX:

Please provide a brief description of your client's current situation, the instant event, etc.

What are some questions you would like addressed in the evaluation?

Are there specific tests or assessments you would like done?

☐	Psychosexual Evaluation	☐	State-of-Mind ("Mens Rea")
☐	Full Psychological Evaluation	☐	ADD/ADHD assessment
☐	IQ assessment	☐	Autism assessment
☐	Memory assessment	☐	Other:
☐	Competency Evaluation (Rule 11)	☐	Other:

Consultation / Research

If you are requesting consultation / research, please briefly describe the topics and questions you have.

Expert Testimony

If you are requesting expert testimony, please briefly describe the psychological matters in question.

Thank you for your interest in Dr. Simpson's forensic services. Please send this form to:

FAX: (520) 355-2000

Email: doc@psy.law