



Brenda K. Roche, Ph.D., LP

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Consent for a Neuropsychological Evaluation of a Minor

Child Name: _____

DOB: _____

Address: _____

Parent or Guardian Name: _____

Parent or Guardian Address: _____

Parent or Guardian Phone: _____

Dr. Brenda K. Roche and I have discussed my child's situation. I have been informed of the risks and benefits of having my child undergo a neuropsychological evaluation. I have had the chance to discuss all of these issues, have had my questions answered, and believe I understand the evaluation that is planned. Therefore, I agree to play an active role in this evaluation as needed, and I give Dr. Roche permission to begin this evaluation, as shown by my signature below.

Signature of parent/guardian

Date

I, the Neuropsychologist, have discussed the issues above with the child's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

Signature of Neuropsychologist

Date

___ Copy accepted by parent/guardian ___ Copy kept by Neuropsychologist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.