

[Provider Name/Clinic Name]

[Address Line 1]

[City, State, Zip Code]

[Phone Number]

[Email Address]

[Date]

[Recipient Name]

[Title/Organization]

[Address Line 1]

[City, State, Zip Code]

**RE: Clinical Assessment Retesting and Consultation for [Patient Name]**

Date of Birth: [DOB]

ID Number: [ID Number, if applicable]

Dear [Recipient Name],

I am writing to formally request/provide a clinical consultation and follow-up retesting for the above-named patient. The patient was previously evaluated on [Original Assessment Date] regarding [Initial Reason for Referral].

The purpose of this retesting and consultation is to:

- Monitor progress since the initial diagnosis and start of treatment.
- Update baseline clinical data to reflect current cognitive/behavioral/psychological functioning.
- Determine the efficacy of current pharmacological or therapeutic interventions.
- Address new symptoms or changes in clinical presentation reported on [Date].

The proposed assessment battery will include [List Tests, e.g., MMPI, WAIS, specific clinical interviews]. Following the completion of these assessments, a consultation meeting is requested to discuss the findings and integrate them into a revised multidisciplinary treatment plan.

Please find the enclosed [or attached] authorization for release of information signed by the patient/guardian. We look forward to coordinating this process to ensure the highest quality of care.

If you require any further clinical documentation or have questions regarding this request, please contact my office at [Phone Number].

Sincerely,

[Signature]  
[Typed Name]  
[Credentials/Title]