PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM

D.C. Official Code § 7-661.01 *et seq*.

Send this form to the Attending Physician

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, MIDDLE):	DATE OF BIRTH:
	SOCIAL SECURITY NUMBER	

B	ATTENDING PHYSICIAN		
	ATTENDING PHYSICIAN'S NAME (LAST, FIRST, M.I.):		BUSINESS TELEPHONE NUMBER: ( ) —
	BUSINESS ADDRESS	FAX NUMBER	EMAIL ADDRESS

C	PSYCHIATRIC / PSYCHOLOGICAL EVALUATION
	1. MEDICAL DIAGNOSIS / DATE(S) OF EXAMINATION(S):
	2. PSYCHIATRIC / PSYCHOLOGICAL EVALUATION

D	PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S INFORMATION	
	□**I have determined through evaluation that the above-named patient <u>is not</u> suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, in conformance with D.C. Official Code 7-661.01 *et seq*.**	
	□**I have determined through evaluation that the above-named patient <u>is</u> suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, in conformance with D.C. Official Code 7-661.01 *et seq.***	
X	CONSULTANT'S SIGNATURE AND TITLE (e.g., M.D., Ph.D., etc.):	LICENSE NUMBER
	CONSULTANT'S NAME (PRINTED):	DATE:
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	TELEPHONE NUMBER: ( ) —