

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		
<input type="checkbox"/> 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 <i>et seq.</i> <input type="checkbox"/> 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 <i>et seq.</i>		
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: () —