PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM

ORS 127.800 - ORS 127.897

<u>Deliver this form to the attending/prescribing physician who will mail it to:</u>
Oregon State Public Health Division, Center for Health Statistics,
P.O. Box 14050, Portland, OR 97293-0050

PLEASE PRINT

| Α | PATIENT INFORMATION | | |
|--|--|----------------------------|--|
| | PATIENT'S NAME (LAST, FIRST, M.I.): | DATE OF BIRTH: | |
| | | | |
| | | | |
| B REFERRING/PRESCRIBING PHYSICIAN | | | |
| | REFERRING PHYSICIAN'S NAME (LAST, FIRST, M.I.): | TELEPHONE NUMBER: | |
| | (=, | | |
| | | | |
| | C PSYCHIATRIC / PSYCHOLOGICAL EVALUATION | | |
| С | 1. MEDICAL DIAGNOSIS | DATE(S) OF EXAMINATION(S): | |
| | 1. MEDICAL DIAGNOSIS | DATE(3) OF EXAMINATION(3). | |
| | | | |
| | 2. PSYCHIATRIC / PSYCHOLOGICAL EVALUATION | | |
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| D PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S INFORMATION | | | |
| | I have determined through evaluation that the above-named patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, in conformance with ORS 127.825. | | |
| | CONSULTANT'S SIGNATURE AND TITLE (e.g., M.D., Ph.D., etc.): | | |
| | | | |
| | CONSULTANT'S NAME (PRINTED): | DATE | |
| | CONSULTANT'S NAME (PRINTED): | DATE: | |
| | | | |
| | MAILING ADDRESS: | | |
| | | | |
| | CITY, STATE AND ZIP CODE: | TELEPHONE NUMBER: | |
| | 0.1.1, 0.1.1.2 / HD 211 0002. | TEEL HOME HOMBER. | |
| | | | |

Copies of this form are available at: http://www.healthoregon.org/dwd