PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM

ORS 127.800 - ORS 127.897

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

PLEASE PRINT

A	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	
	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 is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, in conformance with ORS 127.825.	
	X CONSULTANT'S SIGNATURE AND TITLE (M.D., Ph.D., etc.):	
	CONSULTANT'S NAME (PRINTED):	DATE:
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	TELEPHONE NUMBER:

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

Rev. 5/18