# 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