

**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**

<b>A PATIENT INFORMATION</b>	
PATIENT'S NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:

<b>B REFERRING/PRESCRIBING PHYSICIAN</b>	
REFERRING PHYSICIAN'S NAME (LAST, FIRST, M.I.):	TELEPHONE NUMBER: (       )       —

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

<b>D PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S INFORMATION</b>	
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.	
<b>X</b>	CONSULTANT'S SIGNATURE AND TITLE (e.g., M.D., Ph.D., etc.):
	CONSULTANT'S NAME (PRINTED):
MAILING ADDRESS:	
CITY, STATE AND ZIP CODE:	TELEPHONE NUMBER: (       )       —