



PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM

Deliver this form to the attending physician who will mail it to:

State Registrar, Center for Health Statistics,
P.O. Box 47856, Olympia, WA 98504-7856

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 chapter 70.245 RCW.	
X	CONSULTANT'S ORIGINAL SIGNATURE AND TITLE (e.g., M.D., Ph.D., etc.):
	CONSULTANT'S NAME (PRINTED):
MAILING ADDRESS:	
CITY, STATE AND ZIP CODE:	TELEPHONE NUMBER: () —