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):	DATE:
	MAILING ADDRESS:	
	CITY, STATE AND ZIP CODE:	TELEPHONE NUMBER: ( ) —