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| PSYCHIATRIC CONSULTATION REPORT | | | | | | | | | |
| **Date:** | **Location of Consultant:** | | |
| ***\*Please complete form properly. Both Psychiatrist and Social Worker must sign the form.***  ***\*Submit this form to the Service Office immediately following the psychiatric consult. Attach copies of the Social Histories for all students evaluated.*** | | | | | | | | | |
| STUDENTNAME | | HOME SCHOOL DISTRICT | **DATE OF BIRTH** | **TIME IN** | **TIME OUT** | CONSULTATION | **MEDICATION CHECK** | **EVALUATION** | **SOCIAL HISTORY** ATTACHED **(DATE)** |
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Psychiatrist: Social Worker:

Time In: Time Out: Total Time Seen:

Travel Time: Consultation Time: Evaluation Prep Time: Total Hours:

Rev. 11/19/2014