Attachment B

Miami-Dade County Public Schools
giving our students the world

DIVISION OF SPECIAL EDUCATION

Weekly Contact Log

Psychiatric Consultation

2011-2012

Name of Psychiatrist:: **Month of:**

Name of School Site:

STUDENT NAME (Attach List)	TREATMENT OR CONSULTATION	DATE	TIME FROM	TIME TO	LOCATION OF SERVICE	NUMBER OF PARTICIPANTS	TOTAL HOURS	TOTAL MINUTES	COMMENTS
							TOTAL HOURS		

PD-Professional Development
PC - Parent Consultation
TC - Teacher Consultation
CC - Clinician Consultation
CM - Case Management
SE - Student Evaluation
RK - Record Keeping

I certify that these services have been rendered to the students listed above

Psychiatrist (Signature) **Date**

School Site Clinician (Signature) **Date**