ATTACHMENT A
Miami-Dade County Public Schools
Programs for Students with Emotional/Behavioral Disabilities
Psychiatric Consultation Report

Student's Name:_____ DOB:_____

School Name: _____ Student Id: _____

Clinician Name:_____ Date of Consult:_____

Reports attached? ☐yes ☐no Permission attached? ☐yes ☐no

I. Background Information:

II. Home (Family Constellation? Group Home?):

III. Reason for Referral (Specific questions/concerns) :

IV. Summary of Findings:

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IV. Summary of Findings (Continued):

V. Diagnostic Impression:

- Axis I
- Axis II
- Axis III
- Axis IV
- Axis V

VI. Recommendations:

_____
Psychiatric Consultant

_____
Site Clinician

_____
Date