ATTACHMENT-C
Miami-Dade County Public Schools
Psychiatric Services Summary for Center Schools

Student's Name:_____ DOB:_____

School Name: _____ Student Id: _____

Clinician Name:_____ Date of Consult:_____

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

I. Diagnostic Impression:

- Axis I: _____
- Axis II: _____
- Axis III: _____
- Axis IV: _____
- Axis V: _____

II. Summary of Findings :

Current Medications/Dosages	**Medication Changes – Please indicate dosage changes as well**

III. Overall/Clinical Recommendations:

_____

Psychiatric Consultant