Remote Psychiatric Evaluation Form

Patient Information

Full Name

Date of Birth

Gender

Contact Number

Email Address

Address

Referral Information

Referred By

Reason for Referral

Presenting Problem

Describe the main issues and symptoms:

Medical & Psychiatric History

Medical History

Psychiatric History

Current Medications

Family & Social History

Family History of Psychiatric Illness

Social History (work, school, relationships, etc.)

Mental Status Examination

Appearance & Behavior

Mood & Affect

Thought Process & Content

Cognition (orientation, attention, memory)

Insight & Judgment

Assessment & Plan

Diagnostic Impressions

Treatment Plan & Recommendations

Clinician Name

Date

Signature