Mental Health Doctor’s Note Template

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| --- | --- |
| **Date:** | [MM/DD/YYYY] |
| **Doctor Name:** | [First Name] [Last Name] |
| **Doctor License Number:** | [Doctor License Number] |
| **Doctor Speciality:** | [Speciality] |
| **Doctor Phone Number:** | [0000-000-000] |
| **Doctor Email Address:** | [email@highfile.com] |
| **Patient Name:** | [First Name] [Last Name] |
| **Patient Date of Birth:** | [MM/DD/YYYY] |
| **Patient Address:** | [Complete Address] |
| **City, State, ZIP Code:** | [City, State, ZIP Code] |
| **Patient Phone Number:** | [0000-000-000] |
| **Patient Email Address:** | [email@highfile.com] |
| **Medical History:** |
| Please fill out the below table for the patient's medical history: |
| **Illness/Diagnosis** | **Treatment** | **Date Diagnosed** |
| [Illness/Diagnosis] | [Treatment] | [MM/DD/YYYY] |
| [Illness/Diagnosis] | [Treatment] | [MM/DD/YYYY] |
| [Illness/Diagnosis] | [Treatment] | [MM/DD/YYYY] |
| [Illness/Diagnosis] | [Treatment] | [MM/DD/YYYY] |
| **Current Medical Health Evaluation:** |
| **Date of Evaluation:** | [MM/DD/YYYY] |
| **Diagnosis:** | [Diagnosis] |
| **Symptoms:** | [Symptoms] |
| **Security Symptoms:** | [Security Symptoms] |
| **Treatment Plan:** | [Treatment Plan] |
| **Medication Prescribed:** | [Medication Prescribed] |
| **Recommendation and Accommodation:** |
| Based on my evaluation of the patient, I am making the following recommendations and accommodations. Please fill out the below table: |
| **Recommended Accommodation** | **Duration (Start-End Date)** |
| [Recommended Accommodation] | [MM/DD/YYYY] |
| [Recommended Accommodation] | [MM/DD/YYYY] |
| [Recommended Accommodation] | [MM/DD/YYYY] |
| **Doctor’s Affirmation:** |
| I hereby confirm that the information provided above is accurate and true to the best of my knowledge. I understand that any misrepresentation of the facts can result in penalties under law. |
| **Doctor Signature:** | [Signature] |
| **Date:** | [MM/DD/YYYY] |