**Doctor’s Note for Depression Template**

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| [Doctor's Full Name]  [Doctor's Qualifications]  [Medical License Number]  [Doctor's Contact Information: Phone, Email]  [Hospital/Clinic Name & Address]  **Date:** [MM/DD/YYYY]  To Whom It May Concern,  This is to certify that I have examined and evaluated [Patient's Full Name], Date of Birth: [MM/DD/YYYY], on [Date of Consultation].  **Diagnosis:** Major Depressive Disorder (or specify subtype: e.g., Persistent Depressive Disorder, etc.) | | |
| **Symptoms Presented:** | | |
| **Symptom** | **Severity (Mild/Moderate/Severe)** | **Duration (e.g., 6 months)** |
| **Depressed mood** | [Severity Level] | [Duration] |
| **Loss of interest** | [Severity Level] | [Duration] |
| **Sleep disturbances** | [Severity Level] | [Duration] |
| **Appetite changes** | [Severity Level] | [Duration] |
| **Fatigue** | [Severity Level] | [Duration] |
| **[Additional Symptoms]** | [Severity Level] | [Duration] |
| **[Additional Symptoms]** | [Severity Level] | [Duration] |
| **Treatment Recommended:** | | |
| **Treatment Type** | **Details** | **Duration/Frequency** |
| **Medication** | [Medication Name, Dosage] | [Duration/Frequency] |
| **Psychotherapy** | [Type: e.g., Cognitive Behavioral Therapy] | [Duration/Frequency] |
| **Lifestyle Modification** | [Specifics: e.g., Regular Exercise, Meditation] | [Duration/Frequency] |
| **[Additional Treatment]** | [Details] | [Duration/Frequency] |
| **Special Notes/Recommendations:** | | |
| * It is advised that [Patient's Full Name] take [X days/weeks/months] off work/school to focus on recovery. * Regular follow-ups are necessary to monitor the patient's health and adjust treatments as necessary. * [Additional Recommendations] | | |
| **Confidentiality Note:** | | |
| The medical information contained within this document is confidential and should not be disclosed without the consent of the patient or as required by law. | | |
| **Verification:** | | |
| This note verifies that [Patient's Full Name] has been diagnosed with depression and is under my care. Should you have any queries or require further clarification, please do not hesitate to reach out to the contact details provided above. | | |
| Sincerely,  [Doctor's Signature]  [Doctor's Stamp (if applicable)] | | |