PSYCHIATRY / MENTAL HEALTH VISIT LOG

Date of Visit:	

Child Name:		DOB:		DOP:	

Psychiatry Name:			
Address		Telephone:	

NATURE OF VISIT					
	Psychiatrist		Nurse Practitioner		Psychotherapist

SERVICE PERFORMED					
	Psych. Evaluation		On-Going Treatment		Follow-up Care

DESCRIPTION OF CONDITION WHICH PROMTED THIS VISIT

PRESCSRIBED MEDICATION

Provider Signature & Stamp