DSM-5/DM-ID:2 Psychiatric Evaluation Report

Participant ID #:	
Name (First name & Last name):	
DOB:	____/____/____ [day] [month] [year]
Sex:	☐ Male ☐ Female
Date of Evaluation:	____/____/____ [day] [month] [year]
Name of Clinician:	

DIAGNOSTIC IMPRESSIONS		
Psychiatric Disorder(s)	**Basis of Diagnosis**	**Level of Certainty** (1=Low, 3=Medium, 5=High) [Circle one per psychiatric Dx]
		1 - 2 - 3 - 4 - 5
		1 - 2 - 3 - 4 - 5
		1 - 2 - 3 - 4 - 5
Rule-out:		