PATIENT I.D. DATA:
(name, DOC #, birthdate)

Department of Corrections
WASHINGTON STATE

CONSULTATION PROGRESS RECORD

REFERRING PROVIDER	APPROVAL DATE	CONSULTING PROVIDER/SPECIALTY	FACILITY / UNIT (optional)

Note: All notations must be signed by the responsible health care provider.

DATE MM/DD/YY	TIME USE 24-HR CLOCK	

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.