MEDICAL APPOINTMENT FORM

Client Name: _____ Date of Birth_____ Date of Visit: _____

Consultant Name: _____ Title: (MD, DDS, PT, ETC): _____

See Attached: Written Medication List_____ Copy of Current Medication Administration Record_____
Allergies:_____
Last Tetanus:_____ Date of Pneumovax:_____ Last Influenza Vaccine:_____

Reason for Visit: ER____ Scheduled Appointment____ Lab Work___ X-Ray____ Other _____

Chief Complaint (reason for appointment):

_____
_____
_____

Is Person Competent to consent for medical treatment? Please circle **Yes No**
If no—Guardian/Healthcare Rep: Name_____ Phone Number _____

Staff Accompanying _____ Provider Agency Contact Number_____

Signature of staff completing upper half of form: _____

**********Top Section to be completed by nurse or designee**********

PROVIDER RECOMMENDATIONS / RESULTS

(Include any diagnosis and recommendations for treatment)

_____
_____
_____
_____

Discontinued orders? Yes___No ___If yes, which orders are to be discontinued?

_____

New Orders

Date Ordered	Medication	Strength	Route	Frequency	Reason/Diagnosis	# Refills/ Start Date

Signature of Physician/Consultant: _____ **Date**: _____

FOLLOW UP APPOINTMENT DATE/TIME: _____
Name of Nurse/Supervisor Notified of Above: _____ Date/Time Notified: _____
Staff Notifying: _____ Medications Received Date/Time/Initials _____
Order Transcribed Date/Time/Initials_____

CURRENT MEDICATION ORDERS: (Do not send)

Date Ordered	Medication	Strength	Route	Frequency	Reason/Diagnosis