Quarterly Healthcare Update

Client Name: _____ Date Completed: _____

To be completed by healthcare facilitator prior to Quarterly Meeting. If unable to attend meeting, submit to Case Manager or Program Director prior to meeting.

Months and Year Reviewed:_____

Month	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec
Weight												

Recent Appointments:

Date	Provider	Reason	Recommendations

Up Coming Appointments:

Date	Provider	Reason

Seizures:

Jan. Quantity / Duration		**Feb** Quantity/Duration		**Mar** Quantity/Duration	
Apr Quantity/Duration		**May** Quantity/Duration		**June** Quantity/Duration	
July Quantity/Duration		**Aug** Quantity/Duration		**Sept** Quantity/Duration	
Oct Quantity/Duration		**Nov** Quantity/Duration		**Dec** Quantity/Duration	

Labs and Diagnostics:

Date	Type of test	Results

Quarterly Healthcare Update

Client Name: _____ Date Completed: _____

Medication Additions/Changes:

Date	Medication	Dose	Reason Prescribed	Date stopped

Significant Illness, Injury, ER Visits or Hospitalization:

Date	Brief Description of Problem

IDT Review at Quarterly Meeting Date of Quarterly _____

Appointments:_____

_____

_____

_____

_____

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Quarterly Healthcare Update

Client Name: _____ Date Completed: _____

Signatures of Reviewers:

_____ _____

_____ _____

_____ _____

OR-FN-HS-MA-53(11-9-09)