MEDICAL APPOINTMENT RECORD

STAFF MUST COMPLETE ALL INFORMATION ABOVE DOTTED LINE PRIOR TO APPOINTMENT

The Arc
Prince George's County

_____
Individual's Name

_____
Date of Appointment

_____
Staff Name

Check appropriate specialist or type of appointment:

☐ Primary Care	☐ Urology	☐ Nutritional
☐ Neurology	☐ Nephrology/Kidney	☐ Lab Work
☐ Psychiatry	☐ Pulmonary	☐ X-ray/CT/MRI
☐ Dermatology	☐ Endocrinology	☐ EEG
☐ Hematology	☐ Audiology-Hearing Test	☐ Swallow study
☐ Cardiology	☐ ENT	☐ Colonoscopy
☐ Physical Medicine	☐ Orthopedics	☐ Mammogram
☐ Gastroenterology	☐ PT or ☐ OT	☐ Psychotherapy
☐ Podiatry	☐ Rheumatology	☐ Flu vaccine

☐ MEDICATION INJECTION, med name:_____

FOR GYN, VISION, & DENTAL – USE SPECIFIC APPOINTMENT FORMS

OTHER (specify):_____

Reason for today's visit:_____

MEDICATION ALLERGIES:_____

HEALTH CARE PROFESSIONAL – PLEASE COMPLETE SECTIONS BELOW:

Results of Examination/Diagnosis *(for Psychiatry, please state DSM diagnosis)*:_____
_____
_____

Treatment Given (include immunizations):_____

Follow-Up Care Required:_____

******Please use reverse side for all medication and treatment orders.******

BP_____ P_____ R_____ T_____ O2 Sat_____ Weight_____

Labs ordered:_____ Labs drawn:_____

Other tests ordered:_____ Other tests done:_____

Other instructions or recommendations:_____

Patient may return to work/day program/school on:_____

WHEN SHOULD THIS PATIENT RETURN TO YOUR OFFICE?_____

_____ _____ _____
Health Care Professional Printed Name Signature Date

Next Appointment Date and Time:_____

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Physician/Health Care Professional Medication Order Form (PMOF)

Name of Individual: _____ Name of Staff: _____

Please list all medications/treatments that you wish to order, change, or discontinue:

Name of Medication or Treatment				
Dosage				
Hours/Times to be Given				
Route/Method				
Purpose of Medication or Treatment				
Possible Common Side Effects				
Conditions for which health care professional must be contacted				
STOP DATE	90 days unless other Stop Date stated here:	90 days unless other Stop Date stated here:	90 days unless other Stop Date stated here:	90 days unless other Stop Date stated here:

DISCONTINUED MEDICATIONS—PLEASE LIST BELOW:

1.	2.	3.

In cases where I have ordered behavior modifying medications, I certify that any potential side effect(s) of the medication(s) are outweighed by the behaviors that will occur without the use of the medication, and attempts have been made to gradually decrease the dosage or discontinue the medication(s) when clinically indicated.

Signature of Health Care Professional: _____ Date: _____

Printed Name: _____ Phone: _____