MEDICAL APPOINTMENT RECORD

STAFF MUST COMPLETE ALL INFORMATION ABOVE DOTTED LINE PRIOR TO APPOINTMENT

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

☐ MEDICATION INJECTION, med name:___________________________

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

OTHER (specify):______________________________________________

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

**DISCONTINUED MEDICATIONS—PLEASE LIST BELOW:**

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: ____________________________

Printed Name: ____________________________

Date: ____________________________

Phone: ____________________________