Medical Communication

NAME:_____ Date of Birth:_____

TO BE COMPLETED BY CAREGIVER:

Please describe the nature of the individual's complaint and/or symptoms:

S: Individual states that_____

_____

_____

_____

O: I have observed the following symptoms or behaviors_____

_____

_____

_____

Completed by:_____ Date:_____

TO BE COMPLETED BY MEDICAL (OR DESIGNATED) STAFF:

Please attach the following:

☐ Current Physician Order ☐ Insurance Information ☐ Date of Visit_____

☐ Additional Information/Documentation needed for appointment (if needed)

Type of Service Rendered: Date of Visit: _____

_____

_____

_____

_____

TO BE COMPLETED BY HEALTH CARE PRACTITIONER:

All recommendations will be reviewed by Chimes Health Care Director.

A: Health Care Practitioner Assessment/Findings:_____

_____

_____

P: Health Care Practitioner Recommendations:

Diagnosis:_____

Treatment:_____

Medications:_____

Special Instructions:_____

_____

Return to program/work date:_____

_____ _____ _____

Signature of Health Care Practitioner Date Telephone Number

Please forward pertinent documentation to

CHIMES — 3630 MILFORD MILL ROAD, BALTIMORE, MD 21244-3328

(410) 521-1555 or FAX to (410) 521-4440

Form C-40 Rev. 10/87; 1/88; 8/89; 8/92; 10/92; 6/93; 4/97; 9/97; 5/98; 08/05; 11/06; 03/08; 08/12; 01/14