MEDICAL APPOINTMENT RECORD

I. All of the information on Part I must be completed prior to the appointment. Please write clearly in blue or black ink.

A. Name ________________________________
B. Type of Appointment ________________________________
C. Date of Appointment ____________________ Time: ____________________
D. Name of Practitioner/Clinic ________________________________
   Address/Phone # ____________________________________________
E. Reason for Services __________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
F. Current Allergies, Medications and Dosages – Refer to current physician’s medication order form (PMOF).
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

ALWAYS TAKE THE PERSON’S INSURANCE INFORMATION TO EVERY APPOINTMENT.
MAKE SURE THE EXPIRATION DATE IS CURRENT.

II. This section must be completed in its entirety and signed by the healthcare professional seeing the person.

A. Results of Exam/Diagnosis of Current Medical/Psychiatric Problems ________________________________
   __________________________________________________________
   __________________________________________________________
B. Additional Caregiver Instructions ________________________________
   __________________________________________________________
   __________________________________________________________
C. Signature & Title of Examiner ________________________________
D. Telephone Number of Examiner ________________________________
E. Caregiver with Person Served at Time of Appointment ________________________________

Staff is not to sign any papers indicating they are the representative for the person served receiving medical services. Physical limitations check-list on back ➔
Physical Limitations Check-List

Chimes provides day programs and a vocational program for persons who are developmentally disabled. At all facilities we have Nursing and a Medical Suite on site. Medications are dispensed per doctor’s orders. Within the combination of Chimes sites, we can accommodate a wide variety of physical limitations.

1. Based on this person’s **current injury/illness/condition**, what **additional limitations** will need accommodation for him/her to participate in a day/vocational program? Please check all that apply.

   (I.A.) [ ] No limitation due to this person’s current injury/illness/condition.

   (I.B.) **This person must NOT:**

   [ ] Stand
   [ ] Stand for extended periods (2-4 hours)
   [ ] Lift 10 pounds or less
   [ ] Lift more than 10 pounds
   [ ] Carry items 10 pounds or less
   [ ] Carry items more than 10 pounds
   [ ] Bend at the waist
   [ ] Bend at the knees
   [ ] Walk more than 10 steps at a time
   [ ] Climb stairs
   [ ] Exert upper body range of motion
   [ ] Exert lower body range of motion
   [ ] Independently perform personal care, transferring and mobility
   [ ] Participate in community outings
   [ ] Sit for more than 1 hour at a time
   [ ] Sit for extended periods (4-6 hours at a time)
   [ ] Wear closed toe shoe(s)
   [ ] Be required to be aware of environmental stimuli

   (II) **This person must use the following new medical equipment:**

   ___________________________________________
   ___________________________________________
   ___________________________________________

   (III) **Any additional information:**

   ___________________________________________
   ___________________________________________
   ___________________________________________

   ___________________________________________

   ____________________________  ____________________________
   Signature & Title            Date