Empowering People, Enriching Lives

MEDICAL APPOINTMENT RECORD

I. All of the information on Part I must be completed by the caregiver 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 Medications and Dosages – Refer to current physician's medication order form (PMOF).

G. Allergies

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. Prescribed Treatment

C. Additional Caregiver Instructions

D. Any change in medication? Yes ◯ No ◯

E. Person served is able to return to work (Day Program) on _____

F. Date & Time of Return Visit (If Applicable) _____

G. Signature & Title of Examiner _____

H. Telephone Number of Examiner _____

I. Caregiver with Person Served at Time of Appointment _____

Staff is not to sign any papers indicating they are the representative for the individual receiving medical services.

Nursing Services Provided by **Dimensional Health Care Associates, Inc.**
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