Circle of Support, Inc.

PHYSICIAN'S REPORT

NAME: _____ **DATE:** _____
Reason for visit: _____
_____

Vital Signs: Ht _____ Wt _____ BP _____ Respiration _____ Temperature _____

Current Medication(s):

Name	Dosage	Frequency	Reason

***Are there any side effects observed?** ☐ **Yes** ☐**No**

***If yes, describe:** _____

***Has the benefits and side effects of the medication(s) been reviewed?** ☐ **Yes** ☐**No**

***Essential Findings**

_____

_____

_____

***Current Diagnoses (include additional diagnosis or changes in diagnoses as indicated in the Annual Physical Examination)**

_____

_____

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PHYSICIAN'S ORDER:

_____ **Individual to self-administer medication independently.**

_____ **Individual to participate in self-administration of medication training program.**

***Treatment Plan and/or Special Instruction(s):**

_____

_____

***Next Appointment:**_____

_____ _____ _____
Physician's Name **Date**

_____ _____
Address **Telephone Number**

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