MEDICAL / DENTAL / THERAPY APPOINTMENTS

This form may be emailed to FamilyTouchReporting@gmail.com

Individual's Name: _____ Date of Appointment: _____

Type of Appointment: ☐ Medical ☐ Dental ☐ Other: _____

Reason for visit: _____ Referring Physician: _____

Location: Facility Name: _____ Phone Number: _____

Address: _____

SUMMARY OF VISIT

Medical Professional/ Therapist Name: _____ Position / Title: _____

Summary: _____

_____

_____

_____

_____

_____

Follow-up visit requested: ☐ Yes ☐ No ☐ N/A When: _____

Signature: _____

Attending Provider: _____ Attending Parent / Guardian: _____

Notes / Test Results: _____

_____

_____

_____

Referral(s): ● _____ Issued by: ☐ Print out ☐ Mail ☐ Electronic / Faxed
(Medical Professional / Facility)

● _____ Issued by: ☐ Print out ☐ Mail ☐ Electronic / Faxed
(Medical Professional / Facility)

Subsequent Action Needed:

☐ _____

☐ _____

☐ _____

☐ _____

Vitals:

Wgt: _____ Hgt _____

Blood Pressure: _____

Pulse: ____ O2: _____

PLEASE BRING A CURRENT LIST OF MEDICATIONS TO ALL APPOINTMENTS (excluding therapy sessions)

(12/2018)