MEDICAL / DENTAL / THERAPY APPOINTMENTS

This form may be emailed to FamilyTouchReporting@gmail.com

Individual's Name: _____ Date of Appointment: _____

Location: Facility Name: _____ Phone Number: _____

Address: _____

Type of Testing Performed: Referring Physician: _____

☐ Laboratory: ☐ Blood Work ☐ Urinalysis ☐ Other lab work: _____

Specify: _____

☐ Diagnostic Imaging: ☐ CAT Scan ☐ Ultrasound ☐ MRI ☐ X-Ray ☐ Nuclear

☐ with contrast / tracers ☐ without contrast / tracers

Specify: _____

Preparation required: ☐ Fasting ☐ Non-fasting ☐ N/A ☐ Other: _____

Instructions followed: _____

SUMMARY OF VISIT

Medical Professional Name: _____ Position / Title: _____

Summary of Testing Performed: _____

Medical Professional Signature: _____

Attending Provider: _____ Attending Parent / Guardian: _____

Notes / Test Results: _____

Subsequent Action Needed:

☐ _____

☐ _____

☐ _____

☐ _____

Vitals (if taken)

Wgt: _____ Hgt _____

Blood Pressure: _____

Pulse: _____ O2: _____

PLEASE BRING A CURRENT LIST OF MEDICATIONS TO ALL APPOINTMENTS

(01/2017)