Date of exam: _____

MEDICAL CONTACT FORM

Name: _____ Date of Birth: _____

Allergies: _____

Medications: _____

Pharmacy: _____ Phone: _____ Fax: _____

Provider: _____ Provider's Address: _____ Phone: _____

Medicaid #: _____ Medicare #: _____

Other #: _____

Reason for contact:

Diagnosis/Treatment/Recommendations/Contraindications/Medications Prescribed:

Unless otherwise indicated, I authorize 12 months of refill (or 6 months of refill on controlled medications).

If follow-up is necessary, indicate date needed: _____

_____
(Provider's Signature)

_____
(Date Signed)

Psychotropic med change: Yes ___ No ___

ABLED, Inc. Comments:

_____ _____
Signature/Title Date

Copies: Original to ABLED, Inc. file.

Other: _____ Read by Med Aide (Initial and date) _____