Weight:
Blood Pressure:
Pulse:

THE OTERO CORPORATION
Psychiatrist Visit Form

Individual's Name:
Date:
Psychiatrist:
Time:

Address: ___________________________________ Phone: _____________

Psychiatric Diagnosis: ____

____

Medications and Dosages:,
____

____

Changes in Medications: ____

____

Side Effects Observed (TD, NMS, etc.) ______________________________

____

Lab Work Ordered: ____

____

Special Instructions: ____

____

___________________________ ___________________________
Psychiatrist Signature Staff Signature