DOCTOR VISIT

THE OTERO CORPORATION

"Customer Driven"

Name: _____ Date: _____

Provider: _____ Doctor: _____

Address: _____

Purpose of Visit:
- ◯ Annual Physical
- ◯ Vision
- ◯ Hearing
- ◯ Dental
- ◯ Psychiatry
- ◯ Other: _____

For Medical Provider Only

Summary of Visit:

If Annual Physical Please Check All That Were Checked:
- ◯ Vision
- ◯ Hearing
- ◯ Podiatry
- ◯ Mammogram
- ◯ PAP
- ◯ Prostate Exam

Follow-up Required:

Medication Changes:
- ◯ No
- ◯ Yes. Please explain:

Self Administering Medications

Can this individual self-administer their medications?
- ◯ Yes
- ◯ No. Please explain what support is reccomended:

Signature: _____ Date: _____