

Kalamazoo Community Mental Health and Substance Abuse Services

Medical Visit Form

Consumer: _____ Date of Birth: _____
Health Professional: _____ Date/Time: _____
Clinic: _____ Staff Signature: _____

I am here today because I: (description of presenting issues and needs):

Provider findings: include health provider's observations, lab or x-ray result:

Wt: _____ BP: _____ Pulse: _____ Temp: _____

Diagnosis/findings:

Instructions (treatment and things to watch for):

Medication Orders: Have the provider document any medication orders on a prescription form – to include discontinued medications.

Name of medication	Discontinue	New Orders

Protocol for missed medications:

Standing medication orders:

May resume normal schedule and routine? ___ YES ___ NO Any Restrictions ordered? ___ YES ___ NO

Please describe (i.e. diet, activity level, interactions with others):

Follow up/Referrals/Additional Testing Needed:

Need to return: ___ YES ___ NO IF yes, return date: _____

Additional Comments:

Physician's Signature

Date

Unable to obtain physician's signature

Dissemination: supports coordinator day program staff residential staff guardian

6/27/06