HEALTH CARE PRACTITIONER (HCP) ENCOUNTER FORM

To be completed by provider staff:

Name:	**Date and Time of Appointment:** **Name of Health Care Practitioner:**
Allergies:	
Reason for Visit/Symptoms:	

The following section to be completed by health care practitioner.

Results/Diagnosis:					
Tests/Treatment Ordered:					
New Medications Ordered/Medication Order Change:					
Medication Discontinued: Yes_____ No ____ List:					
Name	**Dose**	**Frequency**	**Route**	**Reason Prescribed**	**Special Instructions**
Follow-up for this problem: **Date/Time:**					
Follow-up for other problem(s) identified at this visit: **Date/Time:** **Explain:**					
If vital signs are indicated, please give parameters and when to call the health care practitioner.					
Health Care Practitioner Signature:_____Print Name:_____					

To be completed by Provider staff who accompanied individual to appointment.

Staff Follow-up: ☐ **Yes** ☐ **No** ☐ **N/A** **Transcribed orders to med log**					
Posted	Date	Time	Verified	Date	Time
Provider Staff Signature			Provider Staff Signature		
☐ **Yes** ☐ **No** ☐ **N/A**	**Communicated results of visit to co-workers/supervisor**				
☐ **Yes** ☐ **No** ☐ **N/A**	**Picked up pharmacy/medication/treatment forms**				
☐ **Yes** ☐ **No** ☐ **N/A**	**Guardian/health care agent/family notified**				
☐ **Yes** ☐ **No** ☐ **N/A**	**Consultation arranged**				
☐ **Yes** ☐ **No** ☐ **N/A**	**Completed lab/x-ray** **Date_____**				
☐ **Yes** ☐ **No** ☐ **N/A**	**Scheduled lab/x-ray** **Date_____**				
Staff Signature (Staff accompanying person):_____					

Adapted from Massachusetts Department of IDD **OR-FN-HS-MA-33(11-9-09)**