Appointment Form

Name _____

Name & Type (Title) of Health Care Provider seeing: _____

Date & Time of Appointment: _____

Address: _____

Phone Number: _____ Staff Accompanying: _____

Type of Visit:

Primary Health Care Provider: _____ Routine Physical _____ Illness _____ Follow-up

Specialist: ____ Audiology _____ Cardiology _____ Dermatology _____ Endocrinology
_____ ENT _____ Gastroenterology _____ Gynecology _____ Nephrology ____ Neurology
_____ Orthopedic ____ Podiatry _____ Psychiatry ____ Pulmonology _____ Urology
____ Vision ____ Other: _____

Therapist: _____ Physical _____Occupational _____ Speech _____ Counseling
_____ Other: _____

Reason for Visit (Explain):

_____

_____

_____

Recommended Forms Attached:

____ Current Physician Order and/or med sheet ____ Current Emergency Medical Sheet
____ Vital Signs____ Incontinence/Sleep Charts _____ Seizure Tracking Form
____ Other: _____

Please schedule follow-up visits at time of office visit if possible…

Return visit: Date _____ Time _____ Reason _____

New Orders Faxed to Pharmacy? □ Yes □ No Date & Time: _____ By: _____

Make a copy for the home file. Appointment forms must be turned in immediately to the manager and forwarded on to the nursing office the same day. If appointment forms are not returned promptly, disciplinary action may be taken.

Residential Staff Person
⇩
ORIGINAL
⇩
Manager
⇩
Community Living Nurse
⇩
Office Tracking Staff

Name _____ Date _____

To be completed by health care provider

Summary of Visit / Instructions for Follow-up:

_____

_____

_____

_____

_____

_____

New Orders:

LABEL: ☐ YES ☐ NO

☐ Refill x
1 2 3 4 5 times
Other: _____
☐ Do not Refill

_____ _____

Dispense as written May Substitute

DEA No. _____

LABEL: ☐ YES ☐ NO

☐ Refill x
1 2 3 4 5 times
Other: _____
☐ Do not Refill

_____ _____

Dispense as written May Substitute

DEA No. _____

I have examined this individual and found no evidence to support the need for continuous skilled nursing care at this time, and certify that he/she is appropriate for Residential placement. I have also found no indication of any condition which might represent a possible hazard to the health or safety of other consumers or to employees.

Health Care Provider Signature_____