FAMILIES FIRST

PHYSICIAN VISIT FORM

Date of Visit : _____

Client's Name: _____

Name of Person with Client: _____

Physician's Name: _____

Reason for Doctor Visit (check all that apply):

_____ Routine Check-Up _____ Annual Physical Exam _____Specialist MD

_____ Sickness or Injury _____ Prescription Renewal _____Dental

_____ Other: _____

Physician Report: _____

_____

_____

_____

Treatment or Medications: _____

_____

_____

Is Follow-Up Needed? _____ Yes _____ No If yes, describe the follow-up plan: _____

_____

_____

Physician's Signature: _____ Date: _____

Case Manager's Signature: _____ Date Received: _____

Guardian's Name: _____ Date Notified: _____

Agency Nurse's Signature: _____ Date Received: _____.

34 E. Main Street, PO Box 939, Wilmington, VT 05363
Phone: (802) 464-9633, Fax: (802) 464-3173, 24hr Emergency Pager: (802) 283-4551
email: FamiliesFirst@familiesfirstvt.com website: www.familiesfirstvt.com