



**PROFESSIONAL SERVICE AND FOLLOW-UP**

**To be completed prior to visit:**

Name \_\_\_\_\_ Date \_\_\_\_\_ Accompanied By \_\_\_\_\_

Treating Professional (Doctor)/Title \_\_\_\_\_ Phone # \_\_\_\_\_

**Reason(s) for the visit:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Acute Illness        | <input type="checkbox"/> Eye Exam             | <input type="checkbox"/> Therapy (type) _____       |
| <input type="checkbox"/> Follow Up            | <input type="checkbox"/> Gyn. Exam            | <input type="checkbox"/> Lab Work (specify) _____   |
| <input type="checkbox"/> Initial Consultation | <input type="checkbox"/> Annual Physical      | <input type="checkbox"/> Diagnostic (specify) _____ |
| <input type="checkbox"/> Acute Injury         | <input type="checkbox"/> Dental Exam/Cleaning | <input type="checkbox"/> Mental Health/Behavior     |
| <input type="checkbox"/> Other _____          |   |   |

Symptoms (severity, frequency, duration) \_\_\_\_\_

Questions \_\_\_\_\_

- |                                   |  |   |
|-----------------------------------|--|---|
| Pertinent Attached Information:   | <input type="checkbox"/> Medication List | <input type="checkbox"/> Current Personal Summary |
| <input type="checkbox"/> Consults | <input type="checkbox"/> Labs            | <input type="checkbox"/> Other _____              |
|                                   | <input type="checkbox"/> Diagnostics     |   |

**To be completed by TREATING PROFESSIONAL:**

Diagnosis \_\_\_\_\_

Progress Note \_\_\_\_\_

Treatment Provided \_\_\_\_\_

New/Changed Medication(s) – Name/Amount/Frequency/Duration \_\_\_\_\_

FOLLOW UP INSTRUCTIONS/ORDERS \_\_\_\_\_

Restrictions for Activities/Work \_\_\_\_\_

Diagnostics \_\_\_\_\_

Labs \_\_\_\_\_

Diet \_\_\_\_\_ Therapy \_\_\_\_\_

Return Visit Needed?  Yes  No If so, when: \_\_\_\_\_

If no improvement in \_\_\_\_\_ days:  Return to office  Call doctor's office/doctor

If worsening:  Return to office  Call doctor's office/doctor

**Signature of Treating Professional:** \_\_\_\_\_ **Date:** \_\_\_\_\_