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:

- ☐ Acute Illness
- ☐ Follow Up
- ☐ Initial Consultation
- ☐ Acute Injury
- ☐ Other _____
- ☐ Eye Exam
- ☐ Gyn. Exam
- ☐ Annual Physical
- ☐ Dental Exam/Cleaning
- ☐ Therapy (type)_____
- ☐ Lab Work (specify)_____
- ☐ Diagnostic (specify)_____
- ☐ Mental Health/Behavior

Symptoms (severity, frequency, duration) _____

_____

Questions_____

Pertinent Attached Information:

- ☐ Consults
- ☐ Labs
- ☐ Medication List
- ☐ Diagnostics
- ☐ Current Personal Summary
- ☐ Other _____

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:**_____