Northern Human Services

Report of Consultation

DATE: _____ Taken to appointment by:_____

NAME: _____ DOB: _____ PHONE # _____

ADDRESS: _____

GUARDIAN: _____ PHONE # _____

Service Coordinator: _____

★ ***ALLERGIES*:** _____

PRIMARY PRACTITIONER: _____ PHARMACY _____

DIAGNOSIS: _____

MEDICARE # _____ MEDICAID # _____

CURRENT MEDICATIONS: **PLEASE SEE LIST ON BACK**

REASON FOR CONSULT:

HEALTH ASSESSMENT: B/P _____ Pulse: _____ R: _____ Weight: _____

RECOMMENDATIONS: (All medications and treatments including OTC's require a prescription with dose, rate & frequency)

DIAGNOSIS:

_____ _____ _____

Date Signature of Consultant Please print name of consultant

Date of follow-up Appointment: _____

Report of Consultation

NAME: _____

CURRENT MEDICATIONS (Include dose, route and ordering practitioner)

Practitioner's signature _____ **Date:** _____