Lutheran Family Services of Virginia

MEDICAL APPOINTMENT REPORT

Date: ____________ Individual Name:____

Doctor's Name/Office: ____
Reason for visit:____

Vital Signs: Weight# ____ BP ____ Pulse ____ Temp ____

Dr's recommendations/New Orders:

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Do any current medications the individual takes need to be discontinued ? YES NO
If Yes - Doctor will need to write DC order for that medication :

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Is follow up appointment needed? YES NO
If Yes - when we are to return:____

Agency Representative present at the appointment :

____

Doctor's Signature:____

3/12KR