St. Clair County Community Mental Health Authority

Medical Appointment Information Record

THIS SECTION TO BE COMPLETED BY HOME

INDIVIDUAL: _____ CASE #: _____ ALLERGIES: _____

ATTENDING PHYSICIAN: _____ DATE OF APPOINTMENT: _____

SYMPTOMS PRESENT: _____

_____

MEDICATIONS (NAMES ONLY): _____

_____

THIS SECTION TO BE COMPLETED BY PHYSICIAN

PHYSICAL FINDINGS: _____

_____

TESTS DONE: _____

_____

DIAGNOSIS AND PROGNOSIS: _____

_____

RESTRICTIONS: _____

_____

PRESCRIPTIONS AND TREATMENTS: _____

_____

RETURN APPOINTMENT DATE: _____

PHYSICIAN'S SIGNATURE: _____

THIS SECTION TO BE COMPLETED BY HOME

DATE RECORDED ON CHRONOLOGICAL: _____

IMPORTANT: IF APPOINTMENT IS CANCELLED, COMPLETE THE FOLLOWING:

INDIVIDUAL RESPONSIBLE: _____

REASON FOR CANCELLATION: _____

DATE: _____ RESCHEDULED DATE: _____

SIGNATURE OF STAFF PERSON: _____