CHAMPLAIN COMMUNITY SERVICES, INC. 512 Troy Avenue, Suite 1, Colchester, VT 05446 655-0511 (P) 655-5207 (F)

MEDICAL OFFICE VISIT REPORT

| Client Name: | Date | <u> </u> | |
|----------------------------------|-------------------------|---------------------|-------------|
| Primary Physician/Clinic | | Physician Seen toda | ıy: |
| Medications: see attached or lis | st any recent additions | | |
| Current Medical Problems: | | | |
| | | | |
| Reason for Visit/Presenting Prob | blem | | |
| Findings Abia Misik | | | |
| Findings this Visit: | | | |
| | | | |
| Necessary Follow-Up: | New Prescriptio | ns? Yes | No |
| | | | |
| | | | |
| Physician's Signature: | | Da | te: |
| Staff Signature | | Dat- | ۵۰ |

Champlain Community Services

Medication List

| Client's Name: | | | | DOB: | |
|---------------------------|----------------|-----------------|----------------------|-------------------|--|
| Allergies: | | | | | |
| Physician's Name: | | | | | |
| Medication Name | Dose | Route | Frequency | Reason for Taking | |
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| | All prescr | iptions need to | be reviewed by a Phy | rsician annually. | |
| Physician's Signature: | | | | | |
| Service Coordinator's Sig | | | | | |
| | Date Notified: | | | | |
| Agency Nurse's Signature | | | | Data: Received: | |