Care for People Plus **Medical/Dental Services Case Note**

Staff are to complete this form down to and including current medications and allergies

Name ____ DOB ________________ Age ____________

Date of Service ____Time of Appointment__________________________

Name of Staff accompanying consumer____

Doctor____Specialty____________________________

Complete in detail reason for visit including symptoms and concerns ________________________________

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May attach separate medication sheet. Please indicate attachment.

Name of Medication	Dose	Times	Purpose	Prescribing Doctor

Allergies:____

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TO BE COMPLETED BY PHYSICIAN/DENTIST:

Diagnosis - ____

Recommendations - ____

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Changes in Medication

Name of Medication	Dose	Times	Purpose	Prescribing Doctor

____ ____

Print Physician's Name Physician's Signature

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Date

Use reverse side for additional information.
Date and sign reverse side if used.