DOCTOR VISIT

Date: _____ Doctor: _____

Participant's Name: _____ DOB: _____

Staff escorting to appointment: _____

Allergies: See Attached

Current Medications, Dx's and Diet: See Attached

Reason for Appointment/ Comments:

TO BE COMPLETED BY ATTENDING PHYSICIAN

Diagnosis and Comments: _____

_____

_____

New Prescription: _____

_____

Have all medication scripts been refilled? ☐ Yes ☐ No

Prescription to be Discontinued: _____

_____

Lab work/Special Testing Ordered: _____

_____

_____ _____

Physician Signature Date

_____

Next Appointment

Paladin, Inc.
Doctor Visit Form
Revised 11/2019

MEDICAL TREATMENT INFORMED CONSENT

Based on the above, I

Check One

☐ Do Agree

☐ Do Not Agree

I was informed of the doctor visit and treatment involved, I

Check One

☐ Do Agree

☐ Do Not Agree

Participant Signature	Date
Guardian Verbal (If Applicable)	Date
Guardian Written (If Applicable)	Date

MEDICAL APPOINTMENT NARRATIVE

Participant (print): _____ Date: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Title