Documentation of Health Care Appointments

Resident’s Name: _____________________________________ Appointment Date: __________

**Part One:** (to be completed by facility staff)

Type of appointment:  
- [ ] Medical  
- [ ] Dental  
- [ ] Psychiatrist  
- [ ] Therapist/Clinician  
- [ ] Other (specify) _____________________________________________________________________

Reason for appointment: ________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Current medications:  
- [ ] No medications taken at this time  
- [ ] See attached MAR  
- [ ] See list below _____________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

All allergies, including medication allergies: ________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Part Two:** (to be completed by health care provider)

Treatment/care provided and Findings: __________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Medication prescribed:  
- [ ] No medication prescribed this visit  
- [ ] Yes, see information below

Drug name: ________________________________ Strength: ________________________________

Schedule for administration: ________________________________ Route: ______________________

Instructions for missed dosage (Physicians Standing Orders): ______________________________
____________________________________________________________________________________

Drug name: ________________________________ Strength: ________________________________

Schedule for administration: ________________________________ Route: ______________________

Instructions for missed dosage (Physicians Standing Orders): ______________________________
____________________________________________________________________________________

* If additional medications were prescribed, please provide required documentation on the back of this form.

Is a follow-up appointment required?  
- [ ] no  
- [ ] yes, next appointment date: ________________________________

Other issues/concerns for staff to be aware of:  
- [ ] no  
- [ ] yes Please explain: _____________________________________________________________
____________________________________________________________________________________

Signature of care provider: ________________________________ Date: ________________________