PROFESSIONAL SERVICE FOLLOW-UP

OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES

PURPOSE: Gives physician information on the individual and allows the physician to provide feedback related to the issue at hand.

COMPLETED BY: Top section to the completed by the individual or staff prior to visit; remainder to be completed by physician during the visit.

WHY THIS IS IMPORTANT:

- Provides written information to physician – why the person is visiting.
- Provides written feedback from physician to staff working with the individual.
- Provides written information on new or changed medication order, treatment received and follow-up instructions.
- Provides a signed physician order without completing an additional form.
- Reminds individual/staff of requested testing or follow-up.

(See Checklist Next Page)

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To be completed prior to visit:

Name_____ **Date**_____ **Accompanied By**_____

Treating Professional (Doctor)/Title_____ **Phone#**_____

Reason(s) for the visit:

☐ Acute Illness	☐ Eye Exam	☐ Therapy (type) _____
☐ Follow-up	☐ Gyn. Exam	☐ Lab Work (specify) _____
☐ Initial Consultation	☐ Annual Physical	☐ Diagnostic (specify) _____
☐ Acute Injury	☐ Dental Exam/Cleaning	☐ Mental Health/Behavior
☐ Other _____		

Symptoms (severity, frequency, duration) _____

_____

Questions _____

Pertinent Attached Information:
☐ Consults ☐ Labs ☐ Medication List ☐ Diagnostics ☐ Current Personal Summary ☐ Other _____

To be completed by TREATING PROFESSIONAL:

Diagnosis _____

Progress Note _____

Treatment Provided _____

_____

_____

_____

New/Changed Medication(s) – Name/Amount/Frequency/Duration _____

_____

_____

_____

FOLLOW-UP INSTRUCTIONS/ORDERS _____

_____

Restrictions for Activities/Work _____
Diagnostics _____
Labs _____
Diet _____ Therapy _____

Return visit needed? ☐ Yes ☐ No If so, when:_____

If no improvement in _____ days: ☐ Return to office ☐ Call doctor's office/doctor
If worsening: ☐ Return to office ☐ Call doctor's office/doctor

Signature of Treating Professional:_____ Date:_____