Adult and Child Center, Inc.

MEDICAL/DENTAL CONSULTATION FORM

Client name:	**Record #:**	**DOB:**
Appointment Date:	**Physician/Dentist:**	
Address:	**Phone:**	

REASON FOR CONSULT
Please check appropriate boxes:

☐ **Annual Physical Exam**	☐ **Illness**	☐ **TB Test**	☐ **Immunizations**	☐ **Vision**
☐ **Annual Dental Exam**	☐ **Routine Service**			

☐ **Other:**

If under 18 years old list height, weight and complete table below: Height: Weight:

Immunizations	Date	By Whom	Immunizations	Date	By Whom

ALLERGIES: ____

MEDICATIONS (List medications or attach MAR)

CONSULTING PHYSICIAN/DENTAL OFFICE REPORT:

SUMMARY OF FINDINGS AND RECOMMENDATIONS::

MEDICATION CHANGES/ADDITIONS:

LAB/CONSULTS ORDERED:

RETURN APPOINTMENT: ☐YES ☐NO If yes: date and time _____

_____ _____
Signature of person completing this consult form Date

IF YOU NEED ADDITIONAL INFORMATION FROM ADULT AND CHILD, PLEASE CONTACT:

_____ _____ _____
Name Phone # Pager #