Medical Consultation Form

INNOVATIONS CAREGIVER TO COMPLETE (PLEASE PRINT)

Client: ______________________________ **Medical Provider/Physician Name:** __________________________

Date of Visit: ________________________ **Medical Provider/Physician Phone Number:** ___________________

Type of Appointment: (Circle One) PCP Dental Hearing Vision Annual Physical Other Specialty: ____________

Allergies: ____

For all Dental & Vision Evaluations:

Please provide us today's charges: $ ______________________
Please indicate if you are planning to bill the Medicaid State Plan? (Please circle) Yes No

Pulse______ Respirations_____ Blood Pressure ___________ Temperature _______ Weight ________

Physician's Progress Notes:

Physician's Orders: ***(Please obtain scripts if needed.)***

Physician's Signature: ____ **Date:** _____________

Recommended Date of Next Exam: ____

ATTENTION PROVIDER: Please fax all labs and testing results to 303-604-5431.

Next Appt: ☐ **1WK** ☐ **2WK** ☐ **1MO** ☐ **3MO** ☐ **6MO** ☐ **1YR** ☐ **2YR** ☐ **Specify:** ________________

Staff Name (Please Print):

Other Notes	Nurse's Follow-up Action NURSE SIGNATURE: _____________________________ Date _____________