VIRGINIA DEPARTMENT OF SOCIAL SERVICES-DIVISION OF LICENSING PROGRAMS
MODEL FORMAT DEVELOPED FOR CHILDEN'S RESIDENTIAL FACILITIES

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:** ______________

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