Physician Appointment Form
Provider # 7600117

This form must be completed PRIOR to the appointment BY STAFF. *Also bring the following information to the appointment: Copy of updated IEI, Copy of updated Medical History Form, Current Physician Orders, and Copy of Medical Services Provider Summary form.*

Name of Medical Service Provider Seeing Patient Today: _____

Date: _____ **Appointment Time:** _____ **am/pm**

Patient/Individual's Name: _____ **Date of Birth**: _____/_____/_____

Address: _____ **City**: _____

State: _____ **Zip**: _____ **Medicaid #** _____

Medication Refills Needed: _____

_____

_____

Reason for Visit:

_____ **New Complaint**

Describe: _____

Date symptoms started**:** _____/_____/_____

Symptoms**:** _____

Duration of Symptoms?_____

Frequency of Symptoms?_____

What causes the issue?_____

What helps relieve the issue?_____

_____ **Follow-up/Recheck**

What was the initial complaint?_____

_____

If rechecking hypertension or diabetes, what have home Blood Pressure and/or Sugar level checks stated? _____

_____

Have symptoms improved? Gotten worse? Remained the same?_____

_____

Treatment:

Has treatment improved, worsened or resolved the issue?_____

Has patient seen a specialist for this issue? _____Yes _____ No

If yes, name of Specialist _____

Last appointment date _____ Next appointment date _____

Please provide a list of the Patient/Individual's specialists. (Provide a copy of Siffrin's Medical Services Provider Summary.)

(over)

_____ **Annual/Wellness Exam** _____

_____

_____

Siffrin staff must ensure that the following items are brought to each appointment:

1) UPDATED IEI, 2) UPDATED MEDICAL HISTORY FORM, 3) CURRENT PHYSICIAN ORDERS (MEDICATIONS)

STAFF/OBSERVANT NOTES REGARDING THE APPOINTMENT: _____

_____

_____

_____

Caregiver/Staff/Observer Signature _____

_____

SIFFRIN STAFF, DO NOT WRITE BELOW THIS LINE – THIS SECTION IS FOR MEDICAL PROVIDER DOCUMENTATION ONLY

VITALS: BP _____ **/** _____ **HEIGHT:** _____ ' _____" **WEIGHT:** _____**lbs**

FINDINGS OF THE EXAMINATION: _____

DIAGNOSIS: _____

TREATMENT, RESTRICTIONS, RECOMMENDATIONS: _____

_____

_____

MEDICATION ORDERS (INCLUDING DISCONTINUED ORDERS): _____

_____

_____

POTENTIAL SIDE EFFECTS: _____

RETURN VISIT NEEDED? _____ **Yes** _____ **No If yes, when?** _____

SIGNATURE OF TREATING PROFESSIONAL: _____ **DATE:** _____

RECALL/FOLLOW-UP APPOINTMENT DATE: _____