Physician's Visit and Order Form

AFH Provider: Fill out this section ahead of appointment as accurately as you can.

Persons Name: **Date:**

AFH-DD Address:

Name of AFH-DD Provider: **AFH Phone:**

Physician's Name: **Dr. Phone #:**

Pharmacy: **Phone #:**

Allergies:

PURPOSE OF VISIT:

CURRENT Medication/Dosage/Route *(Complete this section ahead of appointment, Use back if needed to list additional medications):*

Med	Dosage	Route	Med	Dosage	Route

...This section for physician only.....

SUMMARY OF VISIT-*ORDERS AND INSTRUCTIONS***:**

Attention Physician: Please state orders specifically such as; exact dose, period of time to be given, signs/symptoms to watch for, what any prn medication is for, any follow up visit needed, etc.

Physician Signature **Date**