

SUMMARY OF VISIT



**Take to today's visit.
To be completed by Health Care Practitioner.**

Date _____

Checklist of items to leave with today:

- This form completed
- Completed Residential forms (may be requested for Adult Family Home, Assisted Living, etc.)
- Clinic's visit summary



Name of Health Care Practitioner _____

Location _____ Phone # _____

Next appointment: _____

Schedule at least 30 minutes and the best time of day for the individual

Purpose of next appointment: _____

What did you find during today's visit?

Treatment plan/Recommendations (including any needed referrals) _____

Who else may be involved (physical therapy, occupational therapy, speech therapy, etc.)?

Suggestions for my general good health: _____

Medication:

Any change in medication? Yes No

New Medication	Dose	Purpose	Special instructions

Care provider signature: _____ Date _____