Ardmore Enterprises, Inc.

MEDICAL APPOINTMENT RECORD

1. **THE COUNSELOR, PRIOR TO THE APPOINTMENT, MUST COMPLETE ALL OF THE INFORMATION ON PART 1. PLEASE WRITE/TYPE CLEARLY IN BLUE OR BLACK INK**.

A. PATIENT'S NAME: ____

B. APPOINTMENT DATE AND TIME: ____

C. APPOINTMENT LOCATION AND TELEPHONE NUMBER: ______________________________

____

D. TYPE OF APPOINTMENT: ____

E. REASON FOR APPOINTMENT: ____

____

F. CURRENT MEDICATION (S) AND DOSAGE: ____

____

G. MEDICAL ASSISTANCE#: ____

H. ALLERGIES: ____

I. SIGNATURE OF COUNSELOR WITH PATIENT ______________________ ________________

ALWAYS BRING THE PATIENT'S MEDICAL ASSISTANCE/MEDICARE CARD TO EVERY APPOINTMENT. MAKE SURE THE EXPIRATION DATE IS CURRENT.

2. THIS SECTION MUST BE COMPLETED IN ENTIRETY AND SIGNED BY THE HEALTH CARE PROFESSIONAL SEEING THE PATIENT.

A. FINDINGS: ____

____

____

B. TREATMENT: ____

____

____

C. ADDITIONAL CAREGIVER INSTRUCTION (LAB WORK): _______________________________

____

D. STATEMENT OF MEDICAL NECESSITY FOR LABWORK: ________________________________

____

E. PATIENT IS ABLE TO RETURN TO WORK/DAY PROGRAM ON: __________________________

F. DATE AND TIME OF RETURN/FOLLOW-UP: ____

G. SIGNATURE AND TITLE OF EXAMINER/DOCTOR/OR OTHER PROFESSIONAL: _____________

____

Ardmore Enterprises, Inc. *MEDICATION/TREATMENT ORDER FORM*

Ardmore Enterprises, Inc
3010 Lottsford Vista Rd. Mitchellville MD 20721

NOTE: A non-medical program person may be administering medication/treatment. If possible, arrange a time for administration so that medication/treatment **will not** be given during work program hours (8:30 am – 3:30pm). **All sections must be completed in full!**

NAME: _________________________________ ADDRESS: _______________________________________

TELEPHONE #: ___________________________ COUNSELOR WITH PATIENT: ______________________

PLEASE LIST ALL MEDICATIONS/TREATMENT THAT HAVE BEEN ORDERED AND/OR CANCELLED

NAME OF MEDICATION/TREAMENT				
DOSAGE				
HOURS/TIMES TO BE GIVEN				
METHOD TO GIVE MEDICATION/TREATMENT				
PURPOSE OF MEDICATION/TREATMENT				
STOP DATE				
POSSIBLE COMMON SIDE EFFECT(S)				
CONDITIONS FOR WHICH HEALTH CARE PROFESSIONALS MUST BE CONTACTED				

HEALTH CARE PROFESSIONAL
SIGNATURE-PRINTED: ____________________________ DATE: ___________________

SIGNATURE-SIGNED: _____________________________ DATE: ____________________

THIS FORM MUST BE KEPT CURRENT