



Medical Appointment Record

1405 Hathman Place, Columbia, MO 65201 Fax (573) 876-7319

Consumer's Name _____ D.O.B. _____ Appointment Date _____

Physician's Name _____ Clinic Name _____ Specialty _____

Clinic's Address _____

Clinic's Phone Number _____ Clinic's Fax Number _____

Reason for Appointment _____

Recommendations/Treatment _____

Medication	Dosage	Instructions	Qty	Refills

Controlled Substances MUST be on a separate Prescription

Please also list medications to be discontinued

Substitution Permitted (Physician Signature) _____

Dispense As Written (Physician Signature) _____

**** OFFICE NOTE REQUESTED BY WOODHAVEN STAFF _____**

Lab work ordered : Yes _____ No _____

Lab Ordered	Date to be Drawn
	TODAY: <input type="checkbox"/>
	WITHIN A WEEK: <input type="checkbox"/>
	WITH ANNUAL: <input type="checkbox"/>
	BEFORE NEXT APPT: <input type="checkbox"/>

Physician Signature _____

Location Where Labs Were Drawn _____ Date Labs Drawn _____

Date of Follow-Up Visit: _____

Signature of caregiver who attended the appointment with the consumer: _____

****** Please Request that office notes are sent to Woodhaven's Health Services for our records ******

Always Take Face Sheet And MARs To All Appointments

CC: Health Services, Case Manager, House Record, Program Manager

Please send copies of notes and lab tests To Woodhaven for our records

To Fax:

Woodhaven Health Services **FAX:** 573-876-7319

To Mail:

Woodhaven Health Services
1405 Hathman Place
Columbia, MO 65201

To Call:

Woodhaven Health Services Office: 573-876-7335

Thank-You For Helping Us Take Excellent Care Of Our Consumers !

PLEASE FAX CHART NOTE FOR THIS APPOINTMENT UPON COMPLETION TO THE WOODHAVEN HEALTH SERVICES

INDIVIDUALS NAME: _____ DOB: _____

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____