MEDICAL / DENTAL SERVICE REPORT

Doctor or Facility:			**PCP**	*Indicate Type of Specialist*	**Date:**	
			Specialty:			
Reason for Visit:						

MEDICATIONS ***(List all):*** **HAVE APPROPRIATE PHYSICIAN INDICATE "CONTINUE" OR "D/C"**

Current Meds (including frequently used PRNs)	Corresponding Diagnosis	Prescribing Doctor

ALLERGIES List All**:**

DOCTOR'S REPORT

Report is not valid without the remarks and signature of the attending doctor

DIAGNOSIS	TREATMENT / PLAN OF TREATMENT

Signature of Doctor:		**DATE:**	

New Medication or Dosage Change (List all). Also indicate corresponding diagnosis:

	Referral/Follow-up	Date Scheduled	Location/Doctor

Check here to indicate if there is labwork/test ordered. List date and location results can be obtained; or fax to Progress at 365-0259

Client Name:		**Date of Birth:**	
Progress, Inc Staff Signature:			

I have been informed about the reason for the above medications and possible side effects. I give my consent for these medications.

I was informed by my: Staff _____

Doctor _____

I give consent with my signature _____

Progress, Inc: 319 Ezell Pk, Nashville, TN, 37217
(615) 399-3000

COMPLETE AS TAKEN AT TODAY'S APPOINTMENT							
WEIGHT		B / P		PULSE		TEMP	

COMPLETE PRIOR TO APPOINTMENT					
WEIGHT 6 MONTHS		B / P 6 MONTHS		PULSE 6 MONTHS	
WEIGHT 12 MONTHS		B / P 12 MONTHS		PULSE 12 MONTHS	

AVAILABLE DATA	SLEEP	ELIMINATION	BEHAVIOR	SEIZURE	WEIGHT CHART	OTHER

CHANGES NOTED IN FOLLOWING AREA(S) Describe "usual" and "what is different"
(Sleep, elimination, eating/diet, emotional/behavioral state, seizures, etc)

QUESTIONS I NEED TO ASK THE DOCTOR - AND DOCTOR'S RESPONSE

RECENT ISSUES
(Hospitalizations (medical/psychiatric), recent med changes, lab/test results, illnesses, ER visits, recent transitions or other major life changes, etc)

LIST OTHER SPECIALISTS THE PERSON SEES (PHYSICIAN'S NAME AND SPECIALTY)

PERTINENT MEDICAL HISTORY, INCLUDING IMMEDIATE FAMILY MEDICAL HISTORY