Physician's Visit and Order Form

For Individuals with Developmental Disabilities in Foster Care

....Foster provider to complete prior to appointment....

Patient Name: **Date:**

Patient address:

Foster Care Home Provider: **Phone:**

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

PURPOSE OF VISIT:

ALL CURRENT MEDICATIONS: *(may use back of form or attach MAR if needed)*

Medication name	Dosage	Frequency	Route	Reason

.....Physician to complete.....

SUMMARY OF VISIT

DISCONTINUED ORDERS:

NEW ORDERS AND INSTRUCTIONS/COMMENTS:

Date or duration next follow-up recommended (or mark N/A): _____

Physician Signature **Date**

Note: PRN psychotropic medications are not allowed per Oregon Administrative Rules (OARs) for foster care. Foster providers are required to obtain a Balancing Test in accordance with OARs for any medication with the prescribed intent of which is to affect or alter thought processes, mood, or behavior.

….Foster provider to complete prior to appointment….

ALL CURRENT MEDICATIONS: *(continued from front)*

Medication name	Dosage	Frequency	Route	Reason