

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
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SUMMARY OF VISIT

DISCONTINUED ORDERS: _____

NEW ORDERS AND INSTRUCTIONS/COMMENTS: _____

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

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

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.