HEALTH CARE PRACTITIONER (HCP) CONSULTATION FORM

COMPLETE PRIOR TO APPOINTMENT(Do not leave blank spaces)	
HCP's Name: (credentials)	
Appt Date:	Appt Time:
Reason for Visit:	

PERSON'S INFORMATION		
Person's Name		
DOB:	Sex:	Diet:
Address:		Ph# ( )
Allergies:		
Current Dx(s):		
Other HCP(s):		
MAS Nurse Name: RN/LPN		Contact # ( )
COPY of MAR ATTACHED? (Check One): □ YES □ NO		
Signature of Person Completing Form:		Date:

TO BE COMPLETED BY HCP AND RETURNED WITH PERSON

□ New/Changed Diagnosis: _____

□ Follow-up/Next Appointment Date/Time: _____

CURRENT FINDINGS:

ORDERS: (***Attach Prescriptions to This Form***) _____

_____

HCP Signature _____ (Credentials) Date _____

TO BE COMPLETED BY MAS NURSE

DATE _____ TIME _____ AM/PM

Assessment
T _____ P _____ R _____ BP _____ **S** (What you see, hear, feel, smell, etc.?) **O** (What client says) **A** (Problem) **P** (Changes to Plan of Care?)

Intervention	Y	N	N/A	COMMENTS/NOTES
Follow-up for new problem/ diagnosis?	☐	☐	☐	
New orders received?	☐	☐	☐	
a. Transcribed to MAR?	☐	☐	☐	
b. Communicated to MAC Worker(s)	☐	☐	☐	
c. Communicated to Day Program?	☐	☐	☐	
d. Guardian/Family notified?	☐	☐	☐	
Medications Ordered?	☐	☐	☐	
a. Available at the agency?	☐	☐	☐	
Referrals? (Arranged? Date? Time? Place?)	☐	☐	☐	
a. Lab	▭	▭	▭	
b. X-ray	▭	▭	▭	
c. Procedure	▭	▭	▭	
d. Consult (explain)	▭	▭	▭	

MAS Nurse Signature _____ Date _____

Optional form. Created to help facilitate the communication between provider, Nurse, and treating Physician.