The Moore Center
Creating opportunities for a good life.™

195 McGregor Street, Unit 400
Manchester, NH 03102

Duck #: _____

☐	Annual Physical	**4C**
☐	Psychiatry or Psychology	**4D**
☐	Speech, Language, or Communication	**4E**
☐	Physical Therapy or Occupational Therapy	**4F**
☐	Dental	**4G**
☐	Audiology or Ophthalmology	**4H**
☐	Routine or Emergency Medical	**4I**
☐	Dietary or Diabetic Consultation	**4K**

Medical Health Care Visit Report

Client Name: _____ Date of Visit: _____

Address: _____

Guardian Name: _____ Telephone#: _____

Primary Physician Name: _____ Telephone#: _____

Provider & Specialty seen today: _____

Reason for this appointment or F/U: _____

Client Diagnoses:

Client Allergies:

New / Changed / Discontinued Medications

(Please continue on 2nd page if needed)

Name	Dose	Route	Frequency	Reason	Special Instructions

Medication is: ( ) New ( ) Discontinued ( ) Changed

Name	Dose	Route	Frequency	Reason	Special Instructions

Medication is: ( ) New ( ) Discontinued ( ) Changed

Name	Dose	Route	Frequency	Reason	Special Instructions

Medication is: ( ) New ( ) Discontinued ( ) Changed *(if no changes cross out)*

Health Care Provider Signature: _____ Print Name & Title: _____ Date: _____

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Client Name: _____ Date of Birth: _____

A complete and current list of current medications must be brought to the appointment

Clinical Outcome and/or Follow-Up recommended:

To be completed by HCP/DSP:

DID YOU:

1. Obtain Guardian & Nursing Refusal/Approval for any new or changed medications?

Guardian: _____ Response: _____ Date: _____ Time: _____

Nurse: _____ Response: _____ Date: _____ Time: _____

2. Send/fax copies of all Documentation from this visit within 24 hours to:

( ) Primary Nurse or On-Call Nurse – Name: _____

( ) Program Manager – Name: _____

( ) email Nursing.Department@moorecenter.org OR fax: (603) 206-9010

( ) Residential.Documentation@moorecenter.org

_____ _____

Signature: (HCP/DSP) Print Name & Title: