The Moore Center
Creating opportunities for a good life.™
195 McGregor Street, Unit 400
Manchester, NH 03102

☐	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**

Duck#: _____
Visit Date: _____
Telehealth ☐ Yes ☐ No

Health Care Visit (HCV) Form For Direct Support Professionals (DSP)

This page is to be completed by the DSP

Client Name: _____ Date of Birth: _____

Guardian Name: _____ Telephone#: _____

Medical/Healthcare Provider seen today: _____

Reason for this appointment: _____

Client Diagnoses (from client file/health history form)**:**

Allergies (from client file/health history form)**:**

Send email/fax copies of all documentation from this visit within 24 hours to ALL listed below:

Primary Nurse or On-Call Nurse – Name: _____

☐ Primary Nurse email sent

☐ Emailed Nursing.Department@moorecenter.org ☐ OR Faxed: (603) 206-9010

Medication Changes: ☐ Yes ☐ No

IF YES there was a medication change – Did you obtain Guardian & Nursing Refusal/Approval for any new or changed medications?

Guardian: _____ Response ☐ Yes ☐ No Date: _____ Time: _____

Nurse: _____ Response ☐ Yes ☐ No Date: _____ Time: _____

_____ _____

Direct Support Professional Print Name

Client Name: _____ Duck# _____

This page to be completed by Medical/Healthcare Provider

Reason for this appointment: _____

Clinical Outcome and/or Follow-up Recommendations:

New / Changed / Discontinued Medications

(Please use another copy of this page if needed)

Medication	**Dose**	**Route**	**Frequency**
Reason:			
Special Instructions:			
Medication is : ☐ New ☐ Changed ☐ Discontinued			
Medication	**Dose**	**Route**	**Frequency**
Reason:			
Special Instructions:			
Medication is : ☐ New ☐ Changed ☐ Discontinued			
Medication	**Dose**	**Route**	**Frequency**
Reason:			
Special Instructions:			
Medication is : ☐ New ☐ Changed ☐ Discontinued			
Medication	**Dose**	**Route**	**Frequency**
Reason:			
Special Instructions:			
Medication is : ☐ New ☐ Changed ☐ Discontinued			

Name of Organization _____ Address _____

Healthcare Provider Signature _____ Healthcare Provider Printed Name _____ Date _____