Consultation Form

Individual Name: _____ **Birth Date**: _____

Medicare Number: _____ **Medicaid Number**: _____

Program Name: _____ **Appointment Date Time**: _____

Consultant's Name: _____ **Appointment Type**: _____

Address: _____

Reason for Appointment: _____

Allergies:

_____

_____

_____

Active Diagnoses

ICD-10	DSM-5	ICD-9/DSM-4/Other	Axis	Description	Diagnosis Date	Diagnosed By

Other Medical Information:

_____

_____

_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)

Current Medications:

Medications		Give Amount / Quantity	Frequency	Begin Date	End Date	Prescriber

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)

Findings/Recommendations **Please write medication orders as a separate prescription*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Followup Appointment? **[ ]** Yes **[ ]** No If yes, date/time:

_____

Consultant's Signature: _____ **Date**: _____

Reviewed by

Name: _____ **Title**: _____ **Date**: _____

Name: _____ **Title**: _____ **Date**: _____

Name: _____ **Title:** _____ **Date**: _____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**
Note:- Required fields are marked with an asterisk (*)