MEDICAL APPOINTMENT OUTCOME SHEET

(To be filled-out upon the completion of every medical appointment)

Updated 5/12/03

CONSUMER: _____

PROVIDER: _____ DATE OF APPOINTMENT: _____

PERSON ATTENDING APPOINTMENT: _____
PURPOSE OF APPOINTMENT: _____

OUTCOME OF APPOINTMENT (describe results of appointment, follow-up required, etc.)

_____

_____

Outcome Sheet has been submitted to the following staff member for follow-up & completion:

Name: _____ Date: _____ Time:_____ Initial _____

- **WAS A PRESCRIPTION ORDERED?** ☐ YES ☐ NO
- **IF YES, WAS SCRIPT FILLED AT THE PHARMACY?** ☐ YES ☐ NO ☐ NA
  Note name of medication(s) here☺
  _____
- **DID YOU DOCUMENT CHANGES ON THE MAR?** ☐ YES ☐ NO ☐ NA
- **PRESCRIPTION COPIED & FILED IN MEDICATION BOOK?** ☐ YES ☐ NO ☐ NA
- **PRESCRIPTION ORDERED FOR BEHAVIOR MEDICATION?** ☐ YES ☐ NO ☐ NA

  IF YES, DID YOU CONTACT THE PROGRAM NURSE? ☐ YES ☐ NO ☐ NA

  NURSE CONTACTED: _____ DATE : _____ TIME : _____

- **MEDICATION CHANGES MADE** (New Order/Discontinue/Increase/Decrease) ☐ YES ☐ NO

  IF YES, DID YOU CONTACT THE PROGRAM NURSE? ☐ YES ☐ NO ☐ NA

  NURSE CONTACTED: _____ DATE : _____ TIME : _____

- **CONSULT "ORIGINAL" FILED WITH MAOS?** ☐ YES ☐ NO
  (in nursing section of communication log)
- **CONSULT "COPY" TO NURSE?** ☐ FAXED ☐ IN NURSE MAILBOX
  (In an emergency situation – must be faxed)

- **IS THERE A NEED FOR A FOLLOW-UP APPOINTMENT?** ☐ YES ☐ NO

  IF YES, HAVE YOU SCHEDULED THIS APPOINTMENT? ☐ YES ☐ NO ☐ NA

  DATE: _____ TIME: _____

Please contact a Nurse for any questions or concerns regarding the consumer and/or this appointment.

Review (File after 30 days of appointment)
_____RHM
_____ RN
_____ SC

Feel free to make any comments on the back side of this form.