Physician Visit Documentation

(Please return this form to the facility to ensure clear communication of physician orders)

Name of client: ____

Date of visit: ____

Physician seen: ____

Purpose of visit: ____

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Client accompanied by: ______________________________________

Physician orders/changes (ensure pharmacy is notified of changes):

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☐ Medication Reason for Use Letter (new or updated)
☐ PRN Authorization Letter (new or updated)

Physician's signature: ________________________ Date: __________

For Facility Use Only

Medication changes completed by: ______________________________

Follow up notes/appointments: _________________________________

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Staff reviewed document (each staff initial they have read & understood document):

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