



Wynn-Reeth, Inc.
Physician Visit Form

Client Name: _____ Staff Name: _____ Apt. Date: _____

Doctor's Name: _____ Type of Doctor: _____ Location of Apt.: _____

REASON FOR VISIT: _____

Check one of the following: Office visit phone consult special testing: _____

Name of Med.	Dose	Frequency	Name of Med.	Dose	Frequency
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1. _____ / _____ / _____ 5. _____ / _____ / _____

2. _____ / _____ / _____ 6. _____ / _____ / _____

3. _____ / _____ / _____ 7. _____ / _____ / _____

4. _____ / _____ / _____ 8. _____ / _____ / _____

(Please use reverse side to list other medications.)

Provider Comments:

AREA BELOW TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL ONLY

Vitals: Pulse _____ BP _____ R _____ Temp. _____ Weight _____ (Circle one: up, down, stable)

Chief Complaint: _____

Assessment: _____

Diagnosis: _____

Plan: _____

Labs/Tests ordered: _____

Medication Changes: _____

Diet/Exercise Orders: _____

Work/Activity

Restrictions: _____

Next Appointment: _____ (Please specify the date and time of the next consultation)

Practitioner Signature: _____ Date: _____