Community Services

WCCS-71980-96 [P] (11-10)

Adult Foster Care

Medical/Dental Visit Order Form

Foster Care Provider: *Please complete this section prior to physician visit.*

Resident: ______________________ Date of Birth: ______________________

Diagnosis: ______________________ Allergies: ______________________

Diet: ______________________

Purpose of Visit: ______________________

____

Physician: ______________________ Date of Visit: ______________________

Clinic: ______________________ Telephone: ______________________

Adult Foster Care Provider: ______________________ Telephone: ______________________

Address: ______________________

Authorization for Release of Medical Information

I authorize my physician or clinic to release medical information pertinent for my placement in an adult foster care home to the following:

______________________ ______________________

Provider County Case Manager

______________________ ______________________

Signature of Resident/Guardian Date

Current Medications		
Name	Dosage / Route	Frequency

To be Completed by Medical/Dental Provider:

Results of Examination/Diagnosis: ____________________

____

____

Treatment or Recommendations: ____________________

____

____

Other Orders or Follow Up: ____________________

____

If prescribing medication complete section below

NAME OF MEDICATION	DOSAGE AND FREQUENCY	PURPOSE OR OTHER INSTRUCTIONS: ANY ADVERSE REACTIONS TO BE REPORTED TO PHYSICIAN. May refer to pharmacy side effects sheet. ANY INSTRUCTIONS IF MEDICATION IS NOT TAKEN AS DIRECTED.	MEDICATION ADMINISTRATION: PLEASE CHECK ONE.		
			Takes Independently.	Needs assistance with the following: -Reminders -Storage -Opening -Dispensing -Supervision	Adult Foster Care Provider must administer. Client is not able to self medicate. ***

***Needs to be witnessed and documented by the adult foster care provider. Provider shall not give injectable medication unless they are a registered nurse or there is an agreement signed by the provider, the resident, the physician, and the resident's legal guardian specifying what injections shall be given when and how and the physician shall retain responsibility for the providers giving the injection. A copy of the signed agreement must be retained in the resident's adult foster care record.

Follow up visit: ____________________

Medical/Dental Provider's Signature: ____________________ Date: ____________________