Adolescent and Family Growth Center, Inc.

Medical Consultation Form

Client's name:______________________________ Date/Time:____________________

Name of Physician:____

Address:____

Phone Number:(______)______________________ Fax:__________________________

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* TO BE FILLED OUT PRIOR TO APPOINTMENT:

Nature of complaint / Reason for appointment:

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Medications presently being taken by the client:

Medication	Dose	Days & Times Taken

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* TO BE FILLED OUT BY PHYSICIAN:

Diagnosis / Action Taken by Physician / Procedures Done

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Follow-up appointment necessary: ______No ______Yes

If yes date & time of appointment: Date______________ Time______________

____ ______/_____/______

Physician or Designated Staff Signature Date