

# Physician's Visit and Order Form

For Individuals with Developmental Disabilities in Foster Care

.....Foster provider to complete prior to appointment.....

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient address:** \_\_\_\_\_

**Foster Care Home Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_ **Dr. Phone #:** \_\_\_\_\_

**PURPOSE OF VISIT:** \_\_\_\_\_

**ALL CURRENT MEDICATIONS:** *(may use back of form or attach MAR if needed)*

Medication name	Dosage	Frequency	Route	Reason
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**SUMMARY OF VISIT**

**DISCONTINUED ORDERS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NEW ORDERS AND INSTRUCTIONS/COMMENTS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date or duration next follow-up recommended (or mark N/A): \_\_\_\_\_

.....Physician to complete.....

\_\_\_\_\_  
**Physician Signature** **Date**

*Note: PRN psychotropic medications are not allowed per Oregon Administrative Rules (OARs) for foster care. Foster providers are required to obtain a Balancing Test in accordance with OARs for any medication with the prescribed intent of which is to affect or alter thought processes, mood, sleep, or behavior.*