United Support Services, Inc.

"The works of many coming together for the good of One"

After Visit Summary

Name:		Medicaid #	
DOB:		Record #	

Date of Visit:	
Dr Name:	
Practice:	
Specialty:	☐ Primary ☐ Psych ☐ Neuro ☐ Urology ☐ GI ☐ Dentist ☐Other:

Reason for Visit:	

From Today's Visit:	Weight:	Height:	Temp:	Blood Pressure:
	New Diagnosis:		Vaccine received:	

Ordered:
☐ Labs Ordered ☐ Labs Completed ☐ Labs Reviewed ☐ X-Ray/Scans Ordered ☐ X-Ray/Scans Completed ☐ X-Ray/Scans Reviewed ☐ Diet Change ☐ Other:___________________

Instructions:

Medication Changes			
Change	Medication	Dosage	Instructions (including effective date)
☐Add ☐Discontinue ☐Change			
☐Add ☐Discontinue ☐Change			
☐Add ☐Discontinue ☐Change			
☐Add ☐Discontinue ☐Change			
☐Add ☐Discontinue ☐Change			
☐Add ☐Discontinue ☐Change			

Follow-up Needed:	
Referrals Made To:	
Next Visit:	

Physician's Signature: Date: