TEMPUS UNLIMITED, INC.
Opportunities for Independence
formerly Cerebral Palsy of Massachusetts, Inc.

MEDICAL VISIT FORM

AFC Member's Name _____ Visit Date _____

Last Vital Signs: Date _____ Pulse _____ Temp _____ BP _____ Resp _____ Wt. _____

Date Medication List Updated: Yes _____ No _____

Reason for Doctor Visit: _____

_____

_____

Concerns / Questions: _____

_____

_____

To be Completed by the Physician:

Brief Summary of the Visit: _____

_____

_____

New Orders: _____

_____

_____

_____

Referral to: _____

Follow Up Visit Date: _____

Physician Printed Name: _____ **Date:** _____

Physician Signature: _____

Physician Address and Phone #: _____

_____

Please fax this form to Community Services AFC RN at (978)313-6664 immediately after visit. Thank you.