2250 S. Oneida St. Suite 100, Denver, CO 80224, T (303) 433-1975 F (303)433-1980
1465 N Union Drive Suite 102 Colorado Springs, CO 80909 F: (719) 445-0841

YOUTH'S MEDICAL VISIT FORM

Name of Youth: _____
Date of Birth: _____ **Date of Appointment:** _____

VISIT with…	CHECK ONE BOX BELOW	
Dentist	☐ Routine Preventative Care / Cleaning	☐ Oral Pain or other problem
Medical Doctor (other than psychiatrist)	☐ Periodic Check-up (other than physical at admission)	☐ Scheduled due to Illness
Psychiatrist	☐ Intake Medication Evaluation	☐ Medication Monitoring / Follow-up Visit
Is this a New Provider?	☐ Yes ☐ No	
Other Specialist (specify)	Type of Health Care Provider:	Purpose of Visit:

Name and Type of (MD, RN, DDS, etc.) Health Care Provider _____

Phone Number of Health Care Provider _____

Full Address of Health Care Provider _____

Observation by Health Care Provider (or attach form completed by Health Care Provider):

_____

_____

Recommendation(s); please include any prescriptions: _____

_____

Regular Medication Taken by the Youth (enter in table below):

Name of Medication	Dosage	Times Taken & # of Tablets Taken
Name of Medication	Dosage	Times Taken & # of Tablets Taken
Name of Medication	Dosage	Times Taken & # of Tablets Taken
Name of Medication	Dosage	Times Taken & # of Tablets Taken

Changes in Ongoing Medication (if any): _____

_____

Next Appointment _____

Health Care Provider's Signature _____ **Date** _____

Foster Parent(s) – Please Remember to Update the Youth's Medical Passport! *– It is audited by the state for accuracy*