ABDD Health Care Appointment FORM

Name:	**DOB:**	**Date and Time of Appointment:**
Address:		**Guardian (if applicable):**
Insurance Information and MA#:		
Allergies/Sensitivities:		
Health Care Provider:		**Phone:**
Address:		**Specialty:**
Current Medications:		
Reason for Visit/ Symptoms:		
Tests/Treatments Performed and outcome of visit:		
Were medication related blood levels drawn at this appointment? ☐ **yes** ☐ **no** Send Results to ABDD 295 N. Kerrwood Dr. Ste 108 Hermitage, PA 16148 or Fax to 724-981-3878		
New Medications Prescribed (if new medications are prescribed, please attach copy of script)?		
Other Recommendations:		
Return Visit Needed? ☐ **yes** ☐ **no** **If return visit is needed, date and time of follow up appointment:** **Follow up with PCP or Specialist?** ☐ **yes** ☐ **no** **If return visit is needed, date and time of follow up appointment:**		
Health Care Provider Signature:		**Date:**
Staff Print Name:		