Consultation Report

Washtenaw County Community Support and Treatment Services

Client Name: _____ Client ID: _____

THIS FORM MUST BE ACCOMPANIED BY A RELEASE OF INFORMATION FORM

On (date) _____ Mr./Mrs./Ms. _____ was referred to

(Name/Agency) _____ (Address) _____

by (Staff accompanying resident) _____ for the following problems:

Information which may be helpful to you includes:

ALLERGIES:

PRESENT MEDICATIONS:

OTHER:

IN THE SPACE PROVIDED BELOW AND ON THE REVERSE SIDE OF THIS FORM, PLEASE INDICATE YOUR: 1. Findings; 2. Recommendations; 3. Prescribed Treatment; 4. Need for follow-up
PLEASE SIGN WITH CREDENTIALS AND DATE.

PLEASE RETURN TO:

SIGNATURE AND CREDENTIALS

DATE

ORIGINAL– MEDICAL PROVIDER COPY-CHART

CONSULTATION REPORT–FILE IN HEALTH AND LABS SECTION

PF 9/02