DHS
Oregon Department
of Human Services

Medical Visit Report

Date:_____ **Allergies:** _____ Birth Date:_____
Resident: _____ Facility Name: _____
Address:_____
Resident's Condition/Complaints:_____
_____
_____

Current prescribed medications, treatments and procedures:

Medication/Treatment/Procedure	Dose	Frequency	Route

Summary of visit: _____
_____
_____
_____

New orders and instructions: **(Please note any ending dates for new orders)**
_____
_____
_____

❒ **I have reviewed the resident's current medications and they are correct as shown on this form. Signature constitutes an order.**

_____ _____
Physician's/Nurse Practitioner Signature Date

Please review the following over-the-counter medications the patient uses. Signature constitutes a review only, not an order.

Over-the-counter medications, treatments or topical solutions:

Signed:_____Title:_____Date:_____