LINCOLN STREET INC

EPISODIC PHYSICIAN VISIT

Fill out or FAX after visit summary to: # 802-886-1835

Consumer: ____ Date: ________________

Reason for visit: ____

	Annual
	Dental
	Vision
	ER/Urgent care

	PCP contact
	Neurologist
	OT/PT
	Podiatry

Other: ________________

Physician note: ____

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Medication Order/Change (1) ____

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Medication Order/Change (2) ____

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Medication Order/Change (3) ____

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Follow-up needed: ____

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Practitioners printed name: ____________________________

Practitioners signature: ____ Date: ______________

Practitioners contact number: _(____)_______-______________