ALBERTA PROFESSIONAL SERVICES, INC.
CONSULTATION FORM

Client: Record#:

Date: DOB: Allergies:

DOCTOR'S/CONSULTANT'S NAME:

Reason for Visit:

Medications prescribed or renewed:

Medications discontinued this visit:

□ Education regarding the above medication(s) has been provided in ***writing*** and/or ***orally*** (circle which). This education was provided to the client or responsible person for the purposes of informed consent, safe administration, and compliance with the prescribed regime.

Progress Noted:

Plan/Recommendations:

RETURN APPT NEEDED: YES/ NO DATE & TIME: ________________________________

_______________________________________ _______________________________________
PHYSICIAN'S/ CONSULTANT'S PRINTED NAME PHYSICIAN'S/CONSULTANTS SIGNATURE

_______________________________________ _______________________________________

This forms meets these standards
Authority: 10A NCAC 27G .0209(g)