CLCM Foster Home
Physician's Visit/order Form

DOB: _____ Allergies: _____ Date: _____

Client: _____ Attending Physician: _____

Reason(s) for visit; condition/complaints:

_____

_____

_____

Current Prescribed Medications, Treatments, Procedures, and PRN'S:

Medication/Treatment/Procedure/PRN	Dosage & Frequency	Name of prescribing physician

Summary of Visit:

_____

_____

_____

New Orders & Instructions: (Please note any ending dates for new orders**)**

_____

_____

_____

I have reviewed the client's current medications and they are correct as shown on this form. Signature constitutes an order for medications prescribed by signing physician.

_____ _____

Physician/Nurse Practitioner Signature **Date**

Community Living Case Management
1215 N.E. 7th St ~ Suite F
Grants Pass, Oregon 97526
(541) 474-6072
(541) 474-6280 fax

BALANCING TEST REQUIREMENTS
FOR
LICENSED FOSTER CARE HOMES

Dear Prescriber:

Since there is a need to protect the interests of people with developmental disabilities living in foster care homes, Oregon Administrative Rule 309-040-0052 requires that the foster home staff is required to have your signature on this form prior to the use of psychotropic medications.

I understand that:

1. The staff supporting _____ in the foster care home is required to present me with a full and clear description of behavior or symptoms of the condition to be treated by the psychotropic medication and information on any observed side effects. If needed, the information requested might include the frequency, intensity, and circumstances around the symptoms.

2. The federal Centers of Medicare and Medicaid (CMS) expect the judicious use of psychotropic medications in order to avoid chemical restraints.

   I have reviewed the information given me and believe the use of this medication is In the best interest of _____.

_____ _____
Health Care Provider Signature Date