

# CLCM Foster Home Physician's Visit/order Form

DOB: \_\_\_\_\_ Allergies: \_\_\_\_\_ Date: \_\_\_\_\_

Client: \_\_\_\_\_ Attending Physician: \_\_\_\_\_

Reason(s) for visit; condition/complaints:

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

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

## Summary of Visit:

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

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**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.**

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Community Living Case Management  
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**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

