MEDICAL ENCOUNTER FORM

Patient name: _____

Date of birth: _____

Facility: _____

Date of visit: _____

Name of provider seen: _____

Qualification: MD / DO / PA / NP / Other *if other, specify*: _____

Address: _____

Phone: _____

Reason for evaluation: _____

Summary of relevant findings: _____

Testing performed *(if any)*: _____

Diagnosis: _____

Treatment required *(if any)*: _____

Activity restrictions *(if any)*: _____

Follow up recommended *(if any)*: _____

Additional comments *(if any)*: _____

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