



**FOLLOW-UP MEDICAL/DENTAL FORM**

Client Name: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

DOB: \_\_\_\_\_

Name of Physician or Practice: \_\_\_\_\_

Address and Contact Numbers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Reason for Visit:**

Referral for specialty care (i.e. Cardio, ENT, OB/GYN, etc.)  
Explain nature of referral:

Follow-up with: \_\_\_\_\_  
Explain why follow-up was requested:

**Recommendation or treatment needed (i.e. medications prescribed, appointments, additional referrals, etc.):**

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Signature of Physician or  
Authorized Representative of Practice