CHARITON VALLEY ASSOCIATION, INC

CONSULTATION REPORT AND REQUEST

CLIENT NAME		PHYSICIAN NAME	
BIRTHDATE	SEX MALE □ FEMALE □	CLIENT DMH #	DATE
REQUEST FOR CONSULTATION (PHYSICIAN OR SERVICE)			
BILL □ MEDICAID NUMBER □ MEDICARE NUMBER □ CLIENT'S FUND			
SERVICE COORDINATOR		REGIONAL OFFICE	
REPORT OF CONSULTATION- DIAGNOSIS, FINDINGS AND RECOMMENDATIONS			
DATE	CONSULTANT'S SIGNATURE		

CHARITON VALLEY ASSOCIATION, INC

CONSULTATION REPORT AND REQUEST

IF PRESCRIBING MEDICATION FILL IN BLANKS BELOW:

DATE PRESCRIBING ______________________

MED NAME & STRENGTH ______________________

DIRECTIONS FOR USE ______________________

QUANTITY #: ______________ OR CIRCLE QS

NUMBER OF REFILLS ______________________

DIAGNOSIS ______________________

IF PRESCRIBING MEDICATION FILL IN BLANKS BELOW:

DATE PRESCRIBING ______________________

MED NAME & STRENGTH ______________________

DIRECTIONS FOR USE ______________________

QUANTITY #: ______________ OR CIRCLE QS

NUMBER OF REFILLS ______________________

DIAGNOSIS ______________________

IF PRESCRIBING MEDICATION FILL IN BLANKS BELOW:

DATE PRESCRIBING ______________________

MED NAME & STRENGTH ______________________

DIRECTIONS FOR USE ______________________

QUANTITY #: ______________ OR CIRCLE QS

NUMBER OF REFILLS ______________________

DIAGNOSIS ______________________

DATE	PHYSICIAN'S SIGNATURE