



Our Mission To provide quality services which enhance the lives of people with disabilities.

Appointment Record

Individual's Name: _____ Date: _____ 20 ____

Location of Appointment: _____

Seen By: _____ Who Attended: _____

X-Rays: Yes ☐ No ☐

Reason for Appointment: _____

Outcome/Recommendations: _____

Follow Up (appointment, referral, special equipment, etc.): _____

Staff's Signature: _____ Date: _____ 20 ____

Administrative Signature: _____ Date: _____ 20 ____

Office Use Only

☐ Home

☐ Guardian

☐ Med Record

☐ Record

☐ File

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