



***Circles of Care***  
**Professional Services Report**

This form is to be completed when a child has any type of medical, dental or emergency room visit/appointment for record keeping purposes. Please insure the medical provider completes this form and it is turned into Circle of Care as soon as possible.

**Name of Child** \_\_\_\_\_

**Date of Visit** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Adult/Caregiver Name:** \_\_\_\_\_

**(Type)**

- Initial Medical/Illness**     **Follow up for a medical illness**     **6 month Dental Exam**  
 **Follow up Dental**     **Orthodontist**     **Eye Exam**     **Immunizations or TB**  
 **Annual Well Physical Exam:**(Include Height: \_\_\_\_\_ Weight \_\_\_\_\_ lbs)(Attach annual physical form checklist)  
 **Other (describe):** \_\_\_\_\_

**Complaint or Reason for Visit:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Result of Visit, Test, Treatment, Diagnosis and Recommendations:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication prescribed, dosage and Reason for Medication:** \_\_\_\_\_

(Please specify Meds. continued, D/C, added, increased, decreased from previous appointments)

**Next visit scheduled for and purpose:**  **No follow up required /needed or specify:** \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Doctors Name (please print)**

\_\_\_\_\_  
**Signature of Doctor**

\_\_\_\_\_  
**Doctors Name (for any consulting doctor)**

\_\_\_\_\_  
**Signature of Doctor**

**Address and phone number:** \_\_\_\_\_