

**MEDICAL, DENTAL, OR HEALTH SERVICE CONTACTS**

*FOR A RESIDENT OF A FOSTER HOME SERVING PEOPLE WITH  
DEVELOPMENTAL DISABILITIES*

**I. Information to be completed by Foster provider**

- Name of Resident (Patient): \_\_\_\_\_ Date: \_\_\_\_\_
- Resident's current medications: (use back if additional space is needed)

Medication/Treatment	Dose	Time	Medication/Treatment	Dose	Time

- Reason for visit (describe problem/symptoms):  
\_\_\_\_\_  
\_\_\_\_\_
- Print name of Physician/Dentist/Other health professional: \_\_\_\_\_

**II. Information to be completed by a Physician, Dentist, or other health care professional**

- Diagnosis or Opinion: \_\_\_\_\_  
\_\_\_\_\_
- Recommended Treatment: *(if medication is different from that listed above, please describe change; if medication is PRN list symptoms for when given)*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Date or duration next follow-up recommended (or mark N/A): \_\_\_\_\_
- Precautions or side effects of medication(s): \_\_\_\_\_  
\_\_\_\_\_
- Difficulty obtaining tests: Is there any problem obtaining necessary tests or treatment due to lack of resident cooperation? YES\_\_\_ NO\_\_\_ (If YES, foster provider should contact DD Services Case Manager at (541) 682-3695.)
- SIGNATURE OF PHYSICIAN/DENTIST/ETC:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- If mailed, please return to the following foster provider:

Provider: \_\_\_\_\_

Address: \_\_\_\_\_