DHS
Oregon Department of Human Services
Office of Licensing and Regulatory Oversight

Adult Foster Home Resident Medical Visit Report

Resident information

Name:		Date of birth:	
Adult foster home (AFH):	Accompanied by *(name/relationship)*:		
AFH address:	City:	State:	ZIP code:
Email address:	AFH fax number:	AFH phone:	

Resident medical information

Allergies: ☐ N/A
Medical concerns/reason for visit:

Resident current regimen

This section of page 1 is to be completed by the Adult Foster Home (AFH) provider, prior to appointment and given to the healthcare professional to complete. If additional space is needed, complete and attach page three.

☑ I agree that the following is complete and accurate to the best of my knowledge as prescribed by any and all healthcare professionals for the above resident:

- Prescriptions (Rx);
- Over-the-counter medications (OTC), including any nutritional supplement; and
- Treatments (Tx).

Adult foster home provider's signature _____ Date _____ Phone number _____

Type				Instructions		
Rx:	OTC:	Tx:	Name of current medication, treatment and therapy:	Dose:	Frequency:	Route:
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				

Resident name: _____ Date of birth: _____

Summary of visit

This section is to be completed by a healthcare professional that has prescribing authority.

☐ Continue as stated on page 1 with no changes:

- Prescriptions (Rx);
- Over-the-counter medications (OTC), including any nutritional supplement; and
- Treatments (Tx).

☐ The following changes must be made as directed below.

- List each Rx, OTC and Tx that needs to be changed or modified on a separate line. Include all information for each change and the effective date.

Effective date *(dd/mm/yyyy)*:	Type			Specify the medication, treatment and therapy that is changed, modified or discontinued:	Instructions		
	Rx:	OTC:	Tx:		Dose:	Frequency:	Route:
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				

Professional signature

_____ _____

Prescribing healthcare professional signature Date

Print name and title:			
Street address:			
City:	State:	ZIP code:	Phone number:

Return to the adult foster home for the resident's record.

Resident name: ______________________ Date of birth: ______________

Resident current regimen continued

This section continues from or replaces page 1 and is to be completed by the Adult Foster Home (AFH) provider, prior to appointment and given to the healthcare professional to complete.

☐ I agree that the following is complete and accurate to the best of my knowledge as prescribed by any and all healthcare professionals for the above resident:

- Prescriptions (Rx);
- Over-the-counter medications (OTC), including any nutritional supplement; and
- Treatments (Tx).

Adult foster home provider's signature ______________________ Date ______________ Phone number ______________

Type				Instructions		
Rx:	OTC:	Tx:	Name of current medication, treatment and therapy:	Dose:	Frequency:	Route:
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				
☐	☐	☐				