MEDICAL/DENTAL/PSYCH EXAMINATION REPORT

Name of Client: _____ Date: _____

Purpose of Visit: _____ Routine Exam _____ Follow-Up Appointment

_____ Other (Please Explain): _____ Initial Appointment

Diagnosis / Problem Noted:

Special Instructions/Changes:

_____ _____

Signature of HRT Provider **Date**

Name of Physician / Dentist / Prescriber:

Phone: (_____) _____ - _____

_____ _____

Signature **Date**

Physician/Physician Assistant / Dentist/ Prescriber