

Doctor’s / Professional Case Notes

To be completed by Support Staff

Date: Client’s Name: Doctor’s / Professional’s Name: Reason For Visit: Doctor’s / Professional’s Assessment:

Medication Prescribed: No Yes

Medication Name: Date Prescription was sent to pharmacy: Date Prescription was received from pharmacy: Follow-up instructions:

Guardian in attendance: No Yes

Guardian Informed: No Yes

Next appointment booked (if applicable):

*Signature here*

Name here

 Support Staff Printed Name Support Staff Signature

*Signature here*

Name here

 Case Manager Printed Name Case Manager Signature