Please KEEP YOUR APPOINTMENT
DATE AND TIME. TAKE YOUR MEDICATION
as told by the doctor, nurse or pharmacist.
Bring your medication to each clinic visit.

MEDICATION DOSE FREQUENCY

You should make sure that you receive, all of the care listed. If you don't get these, you should contact your care provider.

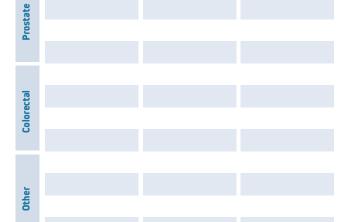
IF FOUND PLEASE TAKE TO THE NEAREST HEALTH CENTRE





N CASE OF <b>EMERGE</b>	NCY PLEA	SE CONTA		
Vame:	100000	Tel:		
Name:				
Address:				
Email:				
Phone:				
Health Facility:				
Initial Registration Date (DD/N	/M/YY):			
M.R. #:	ID/CCP #	<b>#:</b>		
Date of Birth (DD/MM/YY):				
Height (cm/ins):		Weight (Kg/Ll	os):	
BMI at Registration (KG/M):			Sex(M/F):	
Allergies:				
During your medical checku	ρ you should	have the foll	owing:	
All the relevant blood te	ests taken and	d the results (	explained :	to you.
Your blood pressure rec				J
<ul> <li>Your weight recorded at</li> </ul>	t every visit.			
Your urine tested for pr	•	_		
If you have diabetes you eye exam every year.	ur feet checke	ed at every vi	sit and a c	lilated

## Appointment Date Type of Screening Test DD/MM/YYYY DD/MM/YYYY DD/MM/YYYY





✓ Your medication reviewed.

✓ Your nutrition and physical activity pattern reviewed.

✓ If you are on insulin, your injection sites should be checked.
 ✓ The opportunity to discuss any other health problems you have.