Phone Consultation Form

Date: _____ Date Scheduled: _____
Time: _____ Referral ☐ Personal ☐ Call Back ☐ Returned Call ☐
Patient: _____ Caller: _____
Phone No. _____ Address: _____
Credit Card: _____ Exp. Date: _____ CCV: _____
Card Holder: _____ Charge for Consultation: $ _____
Age: _____ Pregnant? _____
Current Prescription Meds: _____

Previous Prescription Meds: _____

Dates Used: _____
Current OTC Meds: _____

Previous OTC Meds: _____

Dates Used:

Presenting Problems:	Allergies:
Assessment:	Diagnosis/Prescription:
Doctor: Initial:	Pharmacy: Initial: