New Castle Regional Office
2540 Wrangle Hill Road, 2nd floor
Bear, DE 19701
PH: (302) 836-2100

Kent Regional: Office, Thomas Collins Bldg.
540 S. DuPont Hwy., Suite 8
Dover, DE 19901
PH: (302) 744- 1110

Sussex Regional Office, Stockley Center:
26351 Patriots Way
Georgetown, DE 19947
PH: (302) 933-3100

Delaware Health & Social Services
Division of Developmental Disabilities Services

Medical Appointment Information Record [MAIR]

Name:_____ MCI#:_____ Date: _____

Ht: _____ Wt: _____ BP: _____ P: _____ Temp: _____

Doctor seen: _____ Specialty:_____

Known Drug Allergies: _____

Symptoms Present:_____

Physical findings:_____

Diagnosis and Prognosis:_____

_____

Restrictions: _____

_____

Prescriptions & Treatment:_____

_____

_____

_____

_____

_____

Return Appointment Date_____

Signature of Doctor: _____
Address: _____

_____

Phone: _____

Name of Individual:_____

MEDICAL APPOINTMENT CHECKLIST

This form must be completed and taken on every doctor's appointment:

- **The following items must accompany you on this appointment:**

☐ Medical Appointment Information Record	☐ COR (Client Oriented Record)
☐ Current MAR	☐ Physical Exam form and Standing Medical Orders (for annual physical only)

- **The following questions must be answered prior to the doctor's appointment:**

What is the nature (purpose) of this appointment?

☐ An annual physical ☐ A follow up appointment

☐ An illness

What symptoms are being experienced? How long have the symptoms been present? (Include when the illness started, how often does it occur and how long does it last? _____

_____

_____

Has this occurred before? YES NO If yes when and what was done for it?

_____

_____

What has been done for the individual to help with this condition?

_____

_____

Signature/Title:_____ Date:_____

At the end of the appointment, these questions should be asked of the doctor:

What care is being ordered?_____

_____

If medication is prescribed, what is the medication supposed to do? (What is the desired effect?) _____

_____

_____

Are there any side effects that we should be concerned about? _____

_____

_____

Signature/Title:_____ Date:_____

PARC Approved: 11/15/04
Revised: 07/21/08, 06/02/09
Form #: 12/Admin