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:

_____

Tests Done:

_____

Diagnosis and Prognosis:

_____

Restrictions:

_____

Prescriptions & Treatment:

_____

Return Appointment Date: _____

Signature of Doctor: _____

Address: _____

Phone: _____

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)
☐ Physical Exam form and Standing Medical Orders (for annual physical only)	☐ Current MAR

- **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: _____

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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, Form #12/Admin