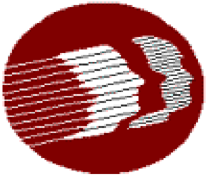

DELAWARE HEALTH & SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

PSYCHIATRIC APPOINTMENT INFORMATION RECORD

Name: ______________________________ MCI #: ______________________ Date: ____________

☐ Initial Appointment ☐ Return Visit

Diagnostic Impressions/ICD-10 Codes:

____

Current findings/recommendations:

____

Symptoms/Targets to be tracked:

____

Specific Staff responses/supports you are requesting:

____

Titration discussed (if applicable):

____

Testing done (e.g.: AIMS) or requested (e.g.: Lab work):

____

Next Appointment: ____________ **Physician's Signature**: ________________________________

Medications: [Include purpose, dosage and frequency]

IDT Members having input & Signatures:

Print Name:__________________________________ Signature: __________________________________

Print Name:__________________________________ Signature: __________________________________

Reviewed and Approved by PARC on 11/15/04
Revised: 10/15/2020
Form #: 13/Admin