**Off Center Appointment Verification and Feedback Form**

Dear Health Care Professional,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is enrolled at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Corps Center

 ***Student Name Center Name***

and has an appointment at on .

***Name of clinic/office Date and Time of appointment***

To best coordinate this student’s health care, would you kindly respond to the questions below, then stamp or sign in the box to verify that student, was seen in your

***Student Name***

office today. This form can be returned via fax to or via e-mail to

***Fax number***

 .

***Email address***

**Summary of visit:** [ ]  Medical [ ]  Mental Health [ ]  Substance Use [ ]  Dental

[ ]  Other:

Any new medications prescribed?

Any changes to current medications?

Please list any special instructions or concerns discussed at today’s appointment that patient should be able to recall or that are important for us to know.

Is a follow-up appointment scheduled? If so, when:

|  |
| --- |
| **(Stamp/Signature)** |

 **Student Authorization for Release of Confidential Information**

I, , hereby authorize and request that agency/person noted above

***Student Name***

release the information requested for this Summary of Visit form.

**Student Signature Date**