**Off-Center Appointment Verification and Feedback Form**

*Please complete this sheet and return to the Job Corps Health and Wellness Center. This will ensure continuity of care between the Job Corps Center providers and your office. Please retain a copy for your records.*

*If you have any questions, please contact the Health and Wellness Center at . Thank you for the care you are providing to our student.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is enrolled at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Corps Center and has an

***Student Name Center Name***

appointment at on .

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

This form can be returned by:  Fax Number

E-mail

Copy provided to student

Summary of visit:  OB Appointment  Other:

If applicable, EDC:

Any new medications prescribed?

Any changes to current medications?

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

Student is in the trade. Any restrictions?

Tests or procedures ordered:

Is a follow-up appointment scheduled?  Yes  No If so, when:

**Off-Center Provider Signature**

**Medical Provider Name Phone Number**

**Medical Provider Signature Date**

**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**

**Center Use Only (to be completed by center medical provider)**

**Center Care Management/Leave Plan:**

**Signature of Center Medical Provider: Date:**