

Recommended Follow Up

Please describe referrals for treatment or therapy, to another provider, or other follow up recommendations.

☐ Return Visit Date and Time: _____

Medications:

New, Refilled, Ongoing, or Discontinued

Medication Name:	Strength, Dose & Frequency (Ex: 10 mg, 1 pill, twice a day)	Reason for Medication:	New	Changed	Discontinued
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Provider Information:

Clinic Name:	Provider Name:	Phone Number:

Caregiver Name	Caregiver Signature	Date of Signature

For a Texas Health Steps Medical Checkup, these elements are required:

- Physical and mental health history
- Comprehensive physical exam
- Address Immunization status
- Required Lab tests as per the Periodicity Schedule
- Health Education
- Hearing and Vision Screening as per the Periodicity Schedule