



Greater Haverhill–Newburyport

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[www.arcofghn.org](http://www.arcofghn.org)

APPOINTMENT SUMMARY FORM

Date of Appointment: \_\_\_\_\_

Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Members Name:	DOB:
Caregiver:	Allergies:
Current Medications: (check ( ) here if brought a copy of Medication Admin. Form)	
Reason for Visit:	
Related information: (ie: seizure activity in last month, medications changes from other MDs, changes in appetite/sleep/behavior, etc Attached data sheets if needed)	
Caregiver Signature:	Date:
<b>PHYSICIAN IMPRESSION:</b>	
<b>RECOMMENDATIONS:</b>	
<b>CHANGES IN MEDICATIONS OR TREATMENTS:</b>	
<b>NEXT VISIT:</b>	
MD Signature:	Date:

**Achieve with us.**

**Member Agency:** The Arc of Massachusetts The Arc of the United States

**Service Areas:** Amesbury, Boxford, Georgetown, Groveland, Haverhill, Merrimac, Newbury, Newburyport, Rowley, Salisbury, West Newbury