The Children's Clinic

Portland Pediatric Clinic
Peterkort Centre 1
9555 SW Barnes Rd., Suite 301
Portland, OR 97225
503.297.3371

Tualatin Pediatric Clinic
Meridian Park Medical Plaza 2
19260 SW 65th Ave., Suite 340
Tualatin, OR 97062
Contact – Heather O'Leary
holeary@childrens-clinic.com

ADHD Med Refill Phone Note: Adolescent XX Test

Caller | Relationship Doctor David Armsby MD

Phone 1 Phone 2

Do not leave message Do not leave message

Parent/patient consents verbally to be part of the PCPCH with TCC: Yes (PCPCH) No (PCPCH)

Consent received by:

Allergies:

Current Problems:

ABDOMINAL DISTENSION (ICD-787.3)
IRON DEFICIENCY (ICD-280.9)

Current Medications:

ALBUTEROL SULFATE 0.083 % NEBU (ALBUTEROL SULFATE) one as directed q 4-6 hour prn wheezing

Weight 32.25 (09/17/2012 1:49:28 PM)

Rx Refills

Name and dose of Medications being refilled:

Effectiveness of Meds:

Side Effects

Sleep Disturbance Yes No

Appetite Disturbance Yes No

Zoning Out Yes No

Goals:

Successes: Other

Other:

Pick up When:

Mail to: Home Address
Other

Home Address: home plant
Portland, OR 97229

Date of last Med Ck or CPX:

Taken by and at:

Provider Notes:

by and at:

Disposition:

by and at:

Prev Form (Ctrl+PgUp) Next Form (Ctrl+PgDn) Close

Medication Check Form: Adolescent XX Test

Nurse Intake

Parent/patient consents verbally to be part of the PCPCH with TCC: ○ Yes (PCPCH) ○ No (PCPCH)

Consent received by:

Accompanied By:

Medication List: ALBUTEROL SULFATE 0.083 % NEBU (ALBUTEROL SULFATE) one as directed q 4-6 hour prn wheezing

Current Medications:

Effectiveness of Current Meds:

Comments:

Side Effects:

Sleep Disturbance ○ Yes ○ No

Appetite Disturbance ○ Yes ○ No

other:

Nurse Signature:

Physician Review

Chief Complaint/Concerns today:

Behavioral Issues:

Home Report: School Report:

Enrolled in special classes? ○ Yes ○ No

Ongoing Communication with teachers? ○ Yes ○ No

Goals:

Successes: Other

Other Comment:

Personal/Family Health History Risk Assessment

Cardiac Risk Factors? ○ Yes ○ No

If yes, specify:

Other Risk Factors? ○ Yes ○ No

If yes, specify:

Behavioral Health Involvement? ○ Yes ○ No

If YES, who? and Phone#:

If NO, was behavior health provider follow up recommended? ○ Yes ○ No

What was the date of the last visit?

Return to Clinic in:

Add 0-4 yr Asthma First Evaluation form | Add 5-11 yr Asthma First Evaluation form | Add 12+ yr Asthma First Evaluation form

Add 0-4 yr Asthma Evaluation of Control form | Add 5-11 yr Asthma Evaluation of Control form | Add 12+ yr Asthma Evaluation of Control form

Prev Form (Ctrl+PgUp) | Next Form (Ctrl+PgDn) | Close