J. Arthur Trudeau Memorial Center
Shared Living Program

"Promoting an enhanced quality of life for individuals with developmental disabilities"

Continuity of Care/Consultation Form for: ______________________________

Date of visit ______________________

Physician Name ______________________

Address ______________________

Phone ______________________

Pharmacy ______________________

Phone Number ______________________

Fax ______________________

Primary Physician's Name ______________________

Fax ______________________

Phone ______________________

To be completed by Shared Living Contractor:

Brief Description of Problem: ______________________________

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To be completed by Physician:

Notes, Diagnoses and Med changes: ______________________________

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Follow-up visit required: ______ Yes ______ No

Date of next visit ______________________

Physician Signature ______________________ Date ______________________

To be completed by Shared Living Contractor:

Please note: physician's findings, recommendations and/or orders for the medical necessity of continuance of professional care (nursing, therapy, dietary, other). Specify treatment, frequency, duration and extent. Include activity limitations: __________

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Shared Living Department follow up:

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