

FUTURES COMMUNITY SUPPORT SERVICES, INC.  
23 MAIN STREET  
TOWANDA, PA 18848  
Phone: (570) 265-3800 Fax: (570) 265-8271

**MEDICAL/LAB/X-RAY APPOINTMENT REPORT**

Name: \_\_\_\_\_

Staff: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Located at:  PCP Office  Specialist Other: \_\_\_\_\_

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

Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diagnostic Tests Administered:

Routine Blood Work: \_\_\_\_\_  X-Rays: \_\_\_\_\_

Urinalysis: \_\_\_\_\_  Blood Levels: \_\_\_\_\_

Scans: \_\_\_\_\_  Other: \_\_\_\_\_

Treatment Provided:

\_\_\_\_\_

Physician Recommends: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Follow-up Appointment: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Review OTC List only if med changes \_\_\_\_\_ Yes \_\_\_\_\_ No

Other Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_