BERKS COUNTY CHILDREN & YOUTH SERVICES
MEDICAL APPOINTMENTS

Child's Name______________________________________

DX: Diagnosis TX: Treatment PX: Prescription

Date:___________________	Date:___________________
Physician/Dentist:___________________	Physician/Dentist:___________________
Reason:___________________	Reason:___________________
Recommendation:___________________	Recommendation:___________________
___________________	___________________
___________________	___________________
___________________	___________________
Date:___________________	Date:___________________
Physician/Dentist:___________________	Physician/Dentist:___________________
Reason:___________________	Reason:___________________
Recommendation:___________________	Recommendation:___________________
___________________	___________________
___________________	___________________
___________________	___________________
Date:___________________	Date:___________________
Physician/Dentist:___________________	Physician/Dentist:___________________
Reason:___________________	Reason:___________________
Recommendation:___________________	Recommendation:___________________
___________________	___________________
___________________	___________________
___________________	___________________
Date:___________________	Date:___________________
Physician/Dentist:___________________	Physician/Dentist:___________________
Reason:___________________	Reason:___________________
Recommendation:___________________	Recommendation:___________________
___________________	___________________
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