



PATIENT I.D. DATA:
(Name, DOC#, DOB)

PRIMARY ENCOUNTER REPORT

DATE	TIME	FACILITY	UNIT (optional)
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Subjective Complaint/Objective Findings/Assessment/Evaluation:

Diagnosis/Plan/Rx: (Diagnosis required for medication orders. Allergies required for new medication orders.)

Risks/benefits of recommended intervention explained; patient consents.

Name and Title of Employee/Contract Staff Performing Encounter:	Signature:
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State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

DOC 320.255 DOC 410.430 DOC 420.250 DOC 420.255 DOC 420.312
DOC 490.850 DOC 610.010 DOC 610.025 DOC 610.600 DOC 670.020