



**NDP-14**  
**NURSE DELEGATION PROGRAM**  
**HEALTH CARE PRACTITIONER**  
**CONSULTATION FORM**

**COMPLETE PRIOR TO APPOINTMENT(Do not leave blank spaces)**

Today's Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Consumer's Name: \_\_\_\_\_  
HCP's Name: \_\_\_\_\_ (credentials)  
Appt Date: \_\_\_\_\_ Appt Time: \_\_\_\_\_  
Reason for Visit: \_\_\_\_\_

**CONSUMER INFORMATION**

MAS Nurse: \_\_\_\_\_ RN/LPN Ph#1 ( )  
DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Ph#2 ( )  
Address: \_\_\_\_\_  
Diet: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Current Dx(s): \_\_\_\_\_  
Other HCP(s): \_\_\_\_\_  
Signature of Person Completing: \_\_\_\_\_ Date: \_\_\_\_\_  
COPY of MAR ATTACHED:  YES  NO

**TO BE COMPLETED BY HCP AND RETURNED WITH CONSUMER**

Current Findings: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
New/Changed Dx: \_\_\_\_\_  
Orders: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
*(Attach Prescriptions to This Form)*  
Follow-up Appt Date: \_\_\_\_\_ Time \_\_\_\_\_  
HCP Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY AGENCY NURSE**

Follow-up for other problem(s) identified at this visit:  Yes  No  None

Date \_\_\_\_\_ Time \_\_\_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Orders Transcribed to MARs:  Yes  No  N/A

Date Transferred to MARs \_\_\_\_\_ Time \_\_\_\_\_  AM  PM

Information communicated to MAC  
Worker(s)/Other Staff  Yes  No  N/A

If Yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications ordered available at program  Yes  No  N/A

Day Program notified of any medication  
changes  Yes  No  N/A

Guardian/family notified  Yes  No  N/A

Consultation Arranged  Yes  No  N/A

Labs/X-rays/Procedures Scheduled  Yes  No  N/A

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NURSE SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_