

McLaren Flint
Bariatric Institute
ENCOUNTER FORM

Date: ____ / ____ / ____

DOCUMENT ALL DIAGNOSES / SIGNS / SYMPTOMS THAT APPLY TO THIS VISIT

Nurse assessment:

T P R BP

Previous WT

Date

HT

WT

Procedures performed / Medications administered:

Physician progress notes:

report dictated

Physician order:

Return to clinic: _____

Physician's Signature: _____ Date: ____ / ____ / ____



025B

PT.

MR.#/RM.

DR.