

Professional Contact Tracking Form

Name of Doctor(s): _____

Name(s) of Key Office Staff: _____

Address: _____

Telephone Number: _____

Type of Practice : _____

Date of Office Visit: _____

Date Follow-up Note Sent: _____

Recommendation to the doctor regarding follow-up at this time: _____ YES _____ NO

Rationale for Recommendation:

Other Comments/Impressions:

Signature of Treatment Coordinator