Specialty Visit Follow up
Continuity and Coordination of Care Report

Today's date: _____

Patient name: _____ **Date of birth:** _____

Date of visit: _____ **Primary diagnosis:** _____

To: _____
Health Care Provider

Address: _____ **Phone:** _____

_____ **Fax:** _____

Your patient was seen on the above date with the above diagnosis. This information is being sent to you for your review and inclusion in the patient's medical record.

The treatment plan is attached.

Comments: _____

_____

The patient was advised to follow up with their primary health care provider within _____ days for further management of their condition.

Respectfully submitted,

_____
(Health Care Provider signature)

Printed name: _____ **Phone:** _____

Address: _____

_____

_____

cc: _____