FOLLOW-UP FORM FOR _____

I. Diagnosis

[ ] Normal _____

[ ] Diagnosis _____

[ ] Other _____

[ ] Attached Lab Results (If Available) _____

II. Treatment:

Date to Treatment: _____
Date First Seen: _____
Comments: _____
Physician Name:_____
Phone: _____

Physician Signature: _____
Date: _____

Return to Special Child Health Services in self addressed envelope.
Thank you for your assistance.

LEPFU6