AFL Monthly Consumer Report

Consumer Name: ___________________________

Record #____________________ MID#_________________________

AFL Provider:___________________________ Month/Year______________________________

Overview:____

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Health Care Visit: ☐ None ☐ Medical ☐ Dental ☐ Therapy ☐ Psychiatric ☐ Medication

Date of Visit: _____________________________
Name of Health Care Professional:____

Reason for Visit: ____

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Is Follow-up necessary: ☐ No ☐Yes- if yes, when? ___________________________________
Preventive Screening or Assessment Completed at Visit: ________________________________

Medical Changes: ☐ No ☐Yes, if yes- was medication education provided?_______________

Attach updated medication order form and copy of Rx

_____________________________________ _____________________________

AFL Provider Signature **Date**

_____________________________________ _____________________________

FamilyTree Representative **Date**