PHYSICIAN DIRECTION FORM

Based on my review of the client's Health Questionnaire, medical, and drug history the following client:

Client Name_____ Client ID#_____

1. ☐ **Must** have the following tests and/or examinations to screen for infectious or communicable disease:_____
After my orders are completed, the results **must** be returned to me for review. The client **may not** participate in the program while the tests are being completed.

2. ☐ **Should** have the following tests and/or examinations to rule out infectious or communicable disease and provide further information for treatment planning purposes:_____
_____
The results may be returned to me for review and further input into treatment planning.

3. ☐ **May** be referred for the following tests and/or examinations for his/her own information and health promotion:_____

_____ _____
Medical Director's Signature Date

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MEDICAL DIRECTOR FOLLOW-UP

Based on my follow-up review of the results of the above tests and/or examinations, the client:

1. ☐ **May** participate in the program.

_____ _____
Medical Director's Signature Date

HIV testing, other than court ordered testing, cannot be mandated.