Patient Encounter Documentation Form

FtP

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Patient Name: **DOB:**	**Medication(s):**
Medication Related Problem(s) *(circle selection)* Date Identified:_____	**Intervention(s)** *(circle selection)* Date Resolved:_____

Blood Pressure Measurement (Date: _____)   _____ mmHg

How reported (circle one; internal use):   Pharmacy-Reported   Patient-Reported

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