

**Human Resources Center, Inc.
AUXILIARY SERVICES REPORT**

Name of Client: _____ **Date:** _____

Name of Facility: _____

Type of Service/Test: _____

Staff: _____

Presenting Problem: _____

Current Medications: _____

Service/Test Provided: _____

Recommendations: _____

Return Visit Required: _____ **Yes** _____ **No** **If YES, Date:** _____

Technician / Therapist Signature