

Visit: _____

CR: _____

Name: _____

Date of Birth: _____

TELEPHONE PRACTICE DOCUMENTATION RECORD

Attending /Physician Service: _____

Date and Time of Call _____
(yyyy/mm/dd) (hhmm)

Name of Caller _____

Address of Caller _____

Telephone Number of Caller _____

Consent Obtained

Reason for Telephone Call

Patient Assessment

Analysis and Plan

(including consultation, education, and referrals)

Protocol/Guideline Used: Yes Specify _____
 No Not applicable

Evaluation and Follow-Up:

Patient to contact family physician
 Patient to go to Emergency Department
 Clinic visit scheduled _____
(yyyy/mm/dd) (hhmm)

Patient to call back if necessary
 Other _____

Printed Name

Designation

Signature

Date (yyyy/mm/dd)

Time (hhmm)

Original- Chart / Yellow – Office