



Hotel
Dieu
Hospital



Client's CR # (if known):
Client's Name:
Client's Date of Birth:

Attending Physician/Service:

TELEPHONE NURSING PRACTICE DOCUMENTATION RECORD

Date and Time of Call _____
yyyy/mm/dd

Name of Caller _____

Address of Caller _____

Telephone Number of Caller _____

Reason for Telephone Call

Patient Assessment (e.g. signs/symptoms, medications/allergies)

Analysis and Plan (including consultation, education, and referrals)

Protocol/Guideline Used: Yes Specify _____
 No Not applicable

Evaluation and Follow-Up:

- | | |
|--|--|
| <input type="checkbox"/> Patient to contact family physician | <input type="checkbox"/> Patient to call back if necessary |
| <input type="checkbox"/> Patient to go to Emergency Department | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Clinic visit scheduled _____ | |

Nurse's Name (Printed)

Nurse's Signature and Designation

Date (yyyy/mm/dd) and Time
