The Patient's Checklist

By Elizabeth Bailey

Supplemental PDF

My Important Health Information

Name: _____

DOB: _____

Insurance (name of carrier and member ID):

_____

My Important Contacts

Contact 1: _____

Phone: _____

Relationship to me: _____

Contact 2: _____

Phone: _____

Relationship to me: _____

My Health-Care Proxy: _____

Phone: _____

I have a health-care proxy: YES NO (see form attached)

I have a living will: YES NO (see form attached)

I use hearing aids ☐, glasses ☐, dentures ☐,
reading glasses ☐.

My current health conditions (including any implants):

_____

_____

Current list of medications, allergies to medication, and over-the-counter meds that I take (name/dose/schedule):

_____

_____

_____

My current doctors (name/number/why I see them):

_____

_____

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DRUG NAME	DESCRIPTION	DAILY SCHEDULE	
		TIME	DOSAGE
DOCTOR	WHY		
SPECIAL INSTRUCTIONS			
ADVERSE REACTIONS			
DATE STARTED			
DATE ENDED			

DATE: ______________________ **DAY:** ______________________

TIME	DRUG	DOSAGE	ROUTE	ON TIME?
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐

NOTES:

DATE: ______________________ **DAY:** ______________________

TIME	DRUG	DOSAGE	ROUTE	ON TIME?
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐

NOTES:

DATE: ______________ **DAY:** ______________

TIME	DRUG	DOSAGE	ROUTE	ON TIME?
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐

NOTES:

DATE: ______________________ **DAY:** ______________________

TIME	DRUG	DOSAGE	ROUTE	ON TIME?
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐

NOTES:

DATE: ______________________ **DAY:** ______________________

TIME	DRUG	DOSAGE	ROUTE	ON TIME?
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐

NOTES:

DATE: ____________________ **DAY:** ____________________

TIME	DRUG	DOSAGE	ROUTE	ON TIME?
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐

NOTES:

DATE: ____________________ **DAY:** ____________________

TIME	DRUG	DOSAGE	ROUTE	ON TIME?
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐

NOTES:

DATE: ______________________ **DAY:** ______________________

TIME	DRUG	DOSAGE	ROUTE	ON TIME?
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐

NOTES:

DATE: ______________________ **DAY:** ______________________

TIME	DRUG	DOSAGE	ROUTE	ON TIME?
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐

NOTES:

DATE: ______________________ **DAY:** ______________________

TIME	DRUG	DOSAGE	ROUTE	ON TIME?
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐
			☐ ORAL ☐ IV ☐ SHOT ☐ OTHER	☐

NOTES:

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse: Shift Time:

Night Nurse: Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse:	Shift Time:
Night Nurse:	Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse: Shift Time:

Night Nurse: Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse:	Shift Time:
Night Nurse:	Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse: Shift Time:

Night Nurse: Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse:	Shift Time:
Night Nurse:	Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse: Shift Time:

Night Nurse: Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse:	Shift Time:
Night Nurse:	Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse: Shift Time:

Night Nurse: Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse:	Shift Time:
Night Nurse:	Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse: Shift Time:

Night Nurse: Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse:	Shift Time:
Night Nurse:	Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

DATE: _____ **DAY # OF HOSPITALIZATION:** ____

NURSES TODAY

Day Nurse: Shift Time:

Night Nurse: Shift Time:

Doctors seen today / Time: ☐

Medications on time and correct? ☐

Invasive devices (IV, catheter, ventilator, etc.) checked by nurse? ☐

Is there a removal date? ☐

What Happened Today? Refer to Daily Reminders Checklist.

RED FLAG

Primary Insurance Provider (adapt from your card info)

Name of policyholder:

DOB and SS# of policyholder*:

Member ID#:

Group#:

Claims phone number:

Contact:

Secondary Insurance Provider (adapt from your card info)

Name of policyholder:

DOB and SS# of policyholder*:

Member ID#:

Group#:

Claims phone number:

Contact:

Prescription Drug ID Card (adapt from your card info)

ID#:

RxGrp:

RxBin:

Employer human resources contact (name/phone/email for contact):

Hospital billing dept. contact (name/phone/email for contact):

***If you are not the policyholder—spouse, parent, etc.**

HOSPITAL INFORMATION PAGE

Date of hospitalization: _____

MRN number: _____

Hospital name: _____

Address: _____

Main number: _____

Nurses' station number for your floor: _____

Nurse manager name and number
for your floor or unit: _____

Room number: _____

Room phone number: _____

Case manager: _____

Social worker: _____

Patient relations number (call if you have issues that
are not being addressed): _____

Rehab facility if applicable: _____

Discharge instructions reviewed with: _____

Discharge services referrals (medical equipment, nursing
services, PT, etc.):

_____

_____

_____

_____

_____

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Special notes:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Special notes:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Special notes:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Special notes:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Special notes:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Doctor name:

Specialty:

Typical time for rounds:

Office phone: Cell phone:

Email:

Office receptionist:

Nurse practitioner: NP contact info:

Physician's assistant: PA contact info:

Hospital resident/intern reporting to doctor:

Contact info:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Name:

Cell: Landline:

Email:

Special notes:

Notes

Notes

Notes

Notes

Notes

Notes

Notes

Notes

Notes

Notes