MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO: Clinical Care Coordinator	FROM: (Requesting physician or activity)	DATE OF REQUEST

REASON FOR REQUEST (Complaints and findings)

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO

DME:

☐ Wheelchair
☐ Walker
☐ Cane
☐ Hospital bed
☐ Nebulizer

☐ Outside referral

☐ Schedule O Test O Procedure O Appointment

☐ Negotiate psychiatric referral

Education:

☐ Glucometer
☐ Coumadin
☐ Asthma
☐ Diabetes
☐ Nutrition

Respiratory needs:

☐ Home O2
☐ Nocturnal O2 saturation
☐ Chest PT
☐ Other needs

Other needs not listed: _____

(Continue on reverse side)

SIGNATURE AND TITLE			DATE
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; rank; rate; hospital or medical facility)*

*U.S. GPO: 1994-377-624

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