OUTPATIENT RECORD

PATIENT

Date/Time/Mode of Arrival:
☐ Walked ☐ Wheelchair ☐ Stretcher
☐ Carried ☐ Other: _____

PHN

Hosp Reg. #

Name:

Add

DOB: YY Age:

Gender: ☐ Male ☐ Female

Brought by: ☐ Self ☐ Police ☐ Relative ☐ Ambulance ☐ Other: _____

Reason for Visit: ☐ Emergency Room ☐ Scheduled Outpatient ☐ Laboratory Dept ☐ Physiotherapy ☐ X-ray ☐ Other: _____

Presenting Problem:

Accident Type: ☐ Traffic ☐ Industrial ☐ Farm ☐ Home ☐ Other: _____

Accident Site: **Date/Time:**

Responsibility for payment *(if not Sask. Health)* ☐ WCB ☐ DVA/DND ☐ Other:

☐ Specify Province and #: Expiry date: YYYY MM DD

If WCB *– Name/Address of Employer)*

Family/Referring Physician:

Attending Physician:

Emergency Notification: *(name, relationship)*

Emergency Phone #'s (H) (W)

Patient's Phone #'s (H) (W)

CONSENT

Repeat Visits	YY	MM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

I, the undersigned, consent or give consent for the above named patient to undergo all necessary examinations, diagnostic test(s) and treatment(s) including local anesthetic that will be required in the course of the diagnosis and treatment of my or the above named patient's illness or condition.
Signature of Patient, Parent or Guardian: _____ Witnessed by: _____

NURSE

VS Time:	
T	BP /
P	SaO_2 %
R	Wt. Kgs
Pain *(0-10)*:	
Other:	

Allergies: *(describe reactions)* ☐ None known ☐ Agency Alert
☐ Medi Alert on
☐ Drug:
☐ Food:
☐ Latex:
☐ Environment:
☐ Facility specific allergy/intolerance record completed

Assessment/Pertinent History:

Current Medications *(list)* ☐ NA
☐ See Best Possible Medication History (BPMH)

Triage Level / Location
☐ **1-R** ☐ **WR**
☐ **2-E** ☐ **TR #** _____
☐ **3-U** **Reassessed at:**
☐ **4-LU**
☐ **5-NU** **Level:**

History of ARO: ☐ Not known ☐ No ☐ Yes*(list)*

Exposure to: ☐ NA ☐ TB ☐ HIV ☐ Hepatitis ☐ Other:

Recent Immunization for: YYYY MM DD ☐ NA
☐ Influenza ☐ Pneumococcal Pneumonia ☐ Other:

Date of last tetanus: ☐ NA

Patient Category

Doctor: **Called at:** **Arrived at:** **Signature:**

PRACTITIONER

Investigation	Done ✓
☐ CBC	
☐ Blood Glucose	
☐ Electrolytes	
☐ Urea	
☐ Creatinine	
☐ Liver Function	
☐ Cardiac Enzymes	
☐ Blood Gas	
☐ Troponin	
☐ ECG	
☐ Urinalysis	
☐ Urine C&S	
☐ C&S Swab:	
☐ X-ray:	
☐ U/S:	
☐ Other:	

Assessment:

Orders:

Discharge Instructions:
Instruction sheet given ☐ Yes ☐ No

Final Diagnosis:

Disposition Time:
☐ Home ☐ Admitted to:
☐ Transferred to:
☐ Deceased ☐ DOA

Condition on discharge:
☐ Improved
☐ No change
☐ Deteriorated

Signature of Practitioner

Copy 1 – Patient Record ***Copy 2 – Attending Physician*** ***Copy 3 – Personal Physician***