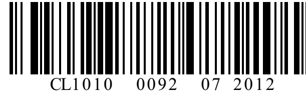
CONSULTATION RECORD



Name

HCN

Date of Birth

Consult Requested/Physician: ______________________

Reason for Consult:

By DR. ______________________ Date/Time: DD/MONTH/YYYY

☐ **URGENT** ☐ Immediate Verbal Contact Time: __________

Results of Contact: ______________________

☐ **NON-URGENT** Provided to: ______________________ Date/Time: DD/MONTH/YYYY

Method of Contact: ☐ Verbal ☐ Facsimile ☐ Mail Other: __________ Date/Time: DD/MONTH/YYYY

Was contact confirmed? ☐ Yes ☐ No Date/Time: DD/MONTH/YYYY

Consultant Assessment: Date/Time: DD/MONTH/YYYY

Decision to Admit/Discharge/Transfer (for ER patients): Date/Time: DD/MONTH/YYYY

Resident's Name: ______________________ Date/Time: DD/MONTH/YYYY

Resident's Signature: ______________________

Consultant's Name: ______________________ Date/Time: DD/MONTH/YYYY

Consultant's Signature: ______________________