



Clinic Office Documents

Signed By: _____ **Signed Date/Time** _____

Synopsis

Feedings

Procedures

Procedures to Avoid	Reasons

Weight:

Wheel Chair Weight:

Baseline Findings

Physical Findings:

Prostheses/Appliances:

Neurological:

Oximetry SATS:

Ancillary (Labs, x-ray, ECG):

Blood Sugars:

Common Presenting Problems

Problems	Suggested Diagnostic Studies	Treatment Considerations

Comments

What are your child's assets/strengths?

What are your child's issues/weaknesses?

Lab Legend: @ = Corrected A = Abnormal C = Critical L = Low H = High R = Ref Lab f = Footnote * = Interpretive Data

Admit Date: 02/28/2011

Patient Name: ZZTEST, WILMAFRED

DOB: 10/21/2010

MR#: 600126

Enc#: 4172896

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Please list any special circumstances/comments/suggestions/what you would like us to know about your child/family?
 (Example: Fears your child may have when coming to the doctor and suggestions to alleviate these fears.)

Medical Equipment

G-Tube Type:

G-Tube Size:

Pumps (type):

Apnea Alarm Settings:

Respirations:

Heart Rate (High):

Heart Rate (Low):

Services

Pharmacy

Preferred Pharmacy	Pharmacy Address	Phone #	Fax #

School Services

Type	Name	Address	Phone #	Fax #

Community Services

Type of Service	Name	Address	Phone #	Fax #

Providers

Physicians

	Name	Address	Office #	Emergency #	Fax #
Primary Care Physician					
Secondary Physician					

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Trinity Hospitals
 One Burdick Expressway West
 Minot, ND 58702-5020

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Specialty Care

Specialty Type	Provider Name	Address	Office #	Emergency #	Followup Information	Active Y/N

Contact Information

Preferred Name:
 Parent(s)/Primary Caregiver(s):
 Cell Phone #:
 Home Phone #:
 Work Phone #:
 Email Address:
 Preferred Contact Method:
 Information Given By:
 Primary Household:
 Siblings Name & DOB:
 Language(s) spoken at home:
 Emergency Contacts:

Emergency Contact Name	Relationship to Patient	Address	Phone #

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