Telephone Triage/Message Form [Sample]

Message taken by:			
Date	Time	Patient Name	
Problem/Patient Complaint:		Current Medications	
Caller's name if not patient: Relationship to patient:		Other Medical Problems Allergies	
Phone #		Patient's Age	Weight
Work Phone #		Pregnant?	Primary Care Physician
Cell Phone #		From ____am/pm To ____ am/pm	
Patient can be reached ☐ at home ☐ on cell ☐ at work			
Problem/Patient Complaint (cont. if necessary):			
Medication refill (circle)		Medication	
Pharmacy Name		Phone #	

Follow up:

☐ ER referral

☐ Appointment made for _____ at _____

☐ Physician to call. Physician called on _____ at _____.

☐ Pharmacy called. Refill ready at _____.

☐ Home health referral

☐ Specialist referral

☐ Communication with patient:

Treatment Plan:

Clinical Advice Given to Patient:

☐ Patient Verbalizes Understanding of Trea tment Plan and/or Clinical Advise Given.

Comment:

☐ Patient Understands to Call Back if Symptoms Worsen or to Call the ER if the Office Is Closed.

Comment:

Call returned by	Date/Time	Provider consulted ☐ Yes ☐ No Provider signature: Date/Time

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