AMBULATORY VISITS RECORD
CSH-185

GENERAL INSTRUCTIONS:

This form must imprinted with the stamp plate by the ward personnel.

Name of clinic - The name of the clinic in which he client is to be seen.

APPOINTMENTS:

Date made - the date the appointment was made

Origin (Building/Ward) - the building and ward or clinic from which the appointment was made.

Initials - the initials of the staff member making the appointment.

Appointment (appt.) Date/Time - the date and time of the actual time for the appointment.

Status - Write in the appropriate code number indicating if appointment was kept, and if not, why.

1. Appointment kept.
2. Appointment canceled by clinic.
3. Appointment canceled by ward.
4. Appointment not kept - other.

NOTE: Document any reason for cancellation in Progress Notes or on consultation sheet.

Follow-up (F/U) Appointment (Appt.) Made - Check here if a follow-up appointment is recommended by the client and attending physician.

Place an “O” if no follow-up appointment is needed; use “PRN” if clinic recommends visits as necessary.

NOTE: The clinic will only make appointments for up to 60 days in advance.

GENERAL INSTRUCTIONS:

The parent ward charge nurse/designee is responsible for keeping this form up to date.

To be sent with the client upon transfer or clinic visit.

Remains a part of the medical record upon discharge.

Upon readmission, to be pulled from the old record and placed in the proper place in the new medical record and up-date stamp plate information.

To include regular scheduled speciality clinic appointments (Medical Surgical and Dental) and emergency visits to the OPC. No to be used for CT series , Brain Scan.