

Emergency Services Call Back Record & Quality Control for LWBS Diagnostic Imaging/Laboratory

Emergency/Urgent Care Staff	to Complete:				
Name of Patient & Hospital I.D. Number:			Patient Telephone:		
Test Ordered:			Date (ddmmyyyy):	Date (ddmmyyyy): Time (hhmm):	
Name of Physician who ordered test:			□ Medical Directive #		
Name of Staff Receiving Test Re					
				Initials	
☐ Diagnostic ☐ Laboratory ☐ Diagnostic ☐ Laboratory					
☐ Diagnostic ☐ Laboratory					
☐ Diagnostic ☐ Laboratory					
☐ Diagnostic ☐ Laboratory					
Emergency Physician was notified: Date (ddmmyyyy): Time (hhmm):					
Emergency Physician to Comp (Emergency Staff to book app	ointments for clinic	s).	ven to patient/family by Emerg	ency Physician	
☐ Patient to follow up with:					
☐ Family Physician:					
☐ Fracture Clinic:Days: Date (ddmmyyyy):			Time (hhmm):	- <u></u>	
☐ Plastics Clinic:Days: Date (ddmmyyyy):			Time (hhmm):		
☐ Other/Comments:					
Completed By:	eted By: Date (ddmmyyyy): Time				
Call Back Attempts Charted: (Emergency Staff to Complete)					
	Date (ddmmyyyy)	Time (hhmm)	Comments/Sign	nature	
☐ Patient Contacted					
□Patient Not Home					
□Message Left					
□No Answer					
☐ 2 nd Attempt					
Letter sent to: □Patient (Form A) Cop	ies to Family Physicia	an □Urgent	□ Non-Urgent		
□Copy of results to <u>Family Physician Only</u> □ Mail			□ Fax		
□Letter sent by:			Date (ddmmyyyy):		
Physicians Signature:			Date (ddmmyyyy):		

