Primary Care Network
CALGARY WEST CENTRAL

ON CALL PHYSICIAN RECORD SHEET

TYPE OF CALL

☐ Health Link ☐ Lab (critical/normal) ☐ Seniors Home Based Primary Care (Home Care RN)

Date of call *(dd/mm/yyyy)*:_____ Time of call:_____

PATIENT INFORMATION

Patient *(last name, first name)*:_____ Phone number:_____

Date of birth *(dd/mm/yyyy)*:_____ Gender:_____ PHN:_____

Parent/guardian name:_____ Family physician:_____

COMPLAINT

☐ Chest pain	☐ Nausea	☐ Cough	☐ Eye concerns
☐ Abdominal pain	☐ Vomiting	☐ Congestion	☐ Labour
☐ Fever	☐ Diarrhea	☐ Sore throat	☐ Pregnancy concerns (not labour)
☐ Reaction/allergies	☐ Constipation	☐ URI	☐ Postpartum care (six weeks postpartum)
☐ Head injury	☐ UTI	☐ Stridor/dyspnea	☐ Infant care concerns
☐ Medication issues	☐ Rash	☐ Other:_____	

PATIENT CONCERNS/RELEVANT HISTORY ☐ Time lab was drawn:_____

PLAN

PATIENT REFERRED TO

☐ Emergency ☐ Urgent care ☐ Family physician ☐ Self care ☐ CWC Primary Care Centre (PCC)

For PCC bookings, leave voicemail at 403.249.9907 with patient name, phone number and any relevant information.

Did this call prevent a visit to the emergency department? ☐ Yes ☐ No

_____ _____

Physician name *(please print)* Physician signature

*** Please fax completed form to 403.249.9976 by noon the following business day.**