# Hospital Contact Record

***"To be completed by designated Provider staff following each conversation with or call to a Physician, nurse or representative of the Hospital"***

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|---|---|
| Date and Time of Call | |
| Name of Person in the Hospital | |
| Name and Title of Person Contacted at Hospital | |
| Number of hours sleeping at night | |
| Number of hours sleeping during day | |
| Percent of Food Eaten last Breakfast | |
| Percent of Food Eaten last Lunch | |
| Percent of Food Eaten last Dinner | |
| Fluid intake by mouth past 24 hours | |
| Fluid intake by IV or other means past 24 hours | |
| Date and time of last bowel movement | |
| Concerns about bowel movements | |
| Date and time of last urine output | |
| Concerns about urine output/fluid retention | |
| Date and time of last Vital Sign Readings | |
| Last Temp, pulse, respiration and Blood Pressure readings | |
| Noted behavioral or emotional issues | |
| New medication or treatment orders since last call | |
| Any medications or treatments discontinued since last call | |
| Does person have an IV | |
| If yes to IV, what is being administered through the IV | |
| Does person have a urinary catheter | |
| Does person have other type of drainage tube - describe | |
| Are all drainage tubes functioning properly | |
| Any tests or lab work since last call | |
| Results of tests or lab work received since last call | |
| Discharge plans | |
| Concerns or comments from hospital staff | |
| Concerns voiced to hospital staff by caller | |
| Other | |
| Agency supervisor or nurse notified of call? | Yes __ No ___ If yes, Name _____ Date_____Time_____ |
| Name and title of person making call to hospital | |