Facility/Physician Telephone Communication Form

Client Name:	DOB:	Room No.:
Facility Name and Address:		
Phone:	Fax:	
Physician:	Date of order:	Time of Order:
Telephone order taken/recorded by:	Title:	
Reason for call: Update Request for order Request for referral Medication Change PRN Med request Other: _____		
Change in consumer status reported/purpose of call:		
Physician's response/order:		

Dear Doctor: The above information is documentation of the telephone call regarding your patient. Please verify the above order, sign and date below. Fax or mail to the facility. Thank you.

Physician Name:	
Date:	Time: