WhatHappensNow.com
GUIDING YOU THROUGH

Hospital Stay Tracking Form

Date created: _____

Take time to fill out this form. Print as many pages or copies as needed for each appointment.

Patient Information

Today's Date/Time: _____

Patient Name: _____

Height/Weight:_____

Blood Pressure: _____

Reason for being in Hospital: _____

_____

_____

_____

Name of Hospital: _____

Address: _____

_____

Room Number: _____

Phone: _____

Doctor Information

Primary Doctor's Name: _____

Dr.'s regular 'round' hours: _____

Phone:_____

E-mail:_____

Nurse's Name/Position on Floor: _____

_____

Nurse's Name/Position on Floor: _____

_____

Nurse's Name/Position on Floor: _____

_____

X-Rays

Reason: _____

Date/Time of Test: _____

Date/Time Results Due: _____

Date/Time You Discussed with Medical Staff:

_____

Results/Next Steps:_____

_____

_____

Reason: _____

Date/Time of Test: _____

Date/Time Results Due: _____

Date/Time You Discussed with Medical Staff:

_____

Results/Next Steps:_____

_____

_____

Reason: _____

Date/Time of Test: _____

Date/Time Results Due: _____

Date/Time You Discussed with Medical Staff:

_____

Results/Next Steps:_____

_____

_____

Lab Test #1

Kind of Test/How will it help? _____
_____
Location/Room of Test: _____
Reason/What are they taking the test for: _____
_____
Date/Time of Test: _____
Date/Time of Results Due: _____
Date/Time You Discussed with Medical Staff:
_____
Results/Next Steps: _____
_____

Test #1

Kind of Test/How will it help? _____
_____
Location/Room of Test: _____
Reason/What are they taking the test for: _____
_____
Date/Time of Test: _____
Date/Time of Results Due: _____
Date/Time You Discussed with Medical Staff:
_____
Results/Next Steps: _____
_____

Lab Test #2

Kind of Test/How will it help? _____
_____
Location/Room of Test: _____
Reason/What are they taking the test for: _____
_____
Date/Time of Test: _____
Date/Time of Results Due: _____
Date/Time You Discussed with Medical Staff:
_____
Results/Next Steps: _____
_____

Test #2

Kind of Test/How will it help? _____
_____
Location/Room of Test: _____
Reason/What are they taking the test for: _____
_____
Date/Time of Test: _____
Date/Time of Results Due: _____
Date/Time You Discussed with Medical Staff:
_____
Results/Next Steps: _____
_____

Lab Test #3

Kind of Test/How will it help? _____
_____
Location/Room of Test: _____
Reason/What are they taking the test for: _____
_____
Date/Time of Test: _____
Date/Time of Results Due: _____
Date/Time You Discussed with Medical Staff:
_____
Results/Next Steps: _____
_____

Test #3

Kind of Test/How will it help? _____
_____
Location/Room of Test: _____
Reason/What are they taking the test for: _____
_____
Date/Time of Test: _____
Date/Time of Results Due: _____
Date/Time You Discussed with Medical Staff:
_____
Results/Next Steps: _____
_____

Medication #1

Name of Medication/Dosage/Schedule Taken:

_____

Date/Time Medication Ordered: _____

Dr's name who ordered it: _____

Kind of medication: (narcotic, etc.) _____

_____

Intended Results: _____

_____

Date/Time Results will be Seen: _____

Possible Side Effects: _____

_____

Estimated date/time side effects should go

away: _____

_____

Dr's estimated next 'round' time: _____

_____

Date/Time Medication Stopped: _____

Dr's name who ordered it: _____

Why Medication was Stopped: _____

_____

_____

Next Steps: _____

_____

_____

_____

Medication #2

Name of Medication/Dosage/Schedule Taken:

_____

Date/Time Medication Ordered: _____

Dr's name who ordered it: _____

Kind of medication: (narcotic, etc.) _____

_____

Intended Results: _____

_____

Date/Time Results will be Seen: _____

Possible Side Effects: _____

_____

Estimated date/time side effects should go

away: _____

_____

Dr's estimated next 'round' time: _____

_____

Date/Time Medication Stopped: _____

Dr's name who ordered it: _____

Why Medication was Stopped: _____

_____

Next Steps: _____

_____

_____

_____

Notes: _____

_____
_____
_____
_____
_____
_____
_____

Medication #3

Name of Medication/Dosage/Schedule Taken:
_____

Date/Time Medication Ordered: _____

Dr's name who ordered it: _____

Kind of medication: (narcotic, etc.) _____
_____

Intended Results: _____
_____

Date/Time Results will be Seen: _____

Possible Side Effects: _____
_____

Estimated date/time side effects should go
away: _____
_____

Dr's estimated next 'round' time: _____
_____

Date/Time Medication Stopped: _____

Dr's name who ordered it: _____

Why Medication was Stopped: _____
_____
_____

Next Steps: _____
_____
_____
_____

Additional Notes:

(Doctor and nurse comments, visiting times for family and friends, patient's general health/ reactions, questions for the doctor, etc.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____