



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:	X-Rays
Patient Name:	Reason:
Height/Weight:	Date/Time of Test:
Blood Pressure:	Date/Time Results Due:
Reason for being in Hospital:	
	results/ reskt steps:
Name of Hospital:Address:	
	Reason:
Room Number:	Data/Times of Took
	Date/Time Posults Due:
Phone:	Date/Time You Discussed with Medical Staff:
Doctor Information	Results/Next Steps:
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:	Results/Next Steps:
	Results/Next Steps:



Lab Test #1	
Kind of Test/How will it help?	_ Test #1
	Kind of Test/How will it help?
Location/Room of Test:	
Reason/What are they taking the test for:	
	Reason/What are they taking the test for:
Date/Time of Test:	
Date/Time of Results Due:	•
Date/Time You Discussed with Medical Staff:	
Docults/Next Stance	Date/Time You Discussed with Medical Staff:
Results/Next Steps:	
Lab Test #2	
Kind of Test/How will it help?	Test #2
	Kind of Test/How will it help?
Location/Room of Test:	Location / Dooms of Took
Reason/What are they taking the test for:	Location/Room of lest.
	Reason/What are they taking the test for:
Date/Time of Test:	Date/Time of Test:
Date/Time of Results Due:	Date/Time of Results Due:
Date/Time You Discussed with Medical Staff:	Date/Time You Discussed with Medical Staff:
Results/Next Steps:	Results/Next Steps:
	-
Lab Test #3	Test #3
Kind of Test/How will it help?	_ Kind of Test/How will it help?
Location/Room of Test:	Location/Room of Test:
Reason/What are they taking the test for:	Reason/What are they taking the test for:
Date/Time of Test:	Date/Time of Test:
Date/Time of Results Due:	
Date/Time You Discussed with Medical Staff:	Date/Time You Discussed with Medical Staff:
Results/Next Stens:	Results/Next Stens:



Medication #1

Name of Medication/Dosage/Schedule Taken:	Medication #2
Date/Time Medication Ordered:	Name of Medication/Dosage/Schedule Taken:
Dr's name who ordered it:	
Kind of medication: (narcotic, etc.)	Date/Time Medication Ordered:
, ,	Dr's name who ordered it:
Intended Results:	
Date/Time Results will be Seen:	Intended Results:
Possible Side Effects:	
	Date/Time Results will be Seen:
Estimated date/time side effects should go	Possible Side Effects:
away:	Estimated date/time side effects should go
Dr's estimated next `round' time:	•
	Dr's estimated next `round' time:
Date/Time Medication Stopped:	
Dr's name who ordered it:	
Why Medication was Stopped:	
	Dr's name who ordered it:
	Why Madiantian was Channed.
Novt Change	
Next Steps:	
	North Change
Notes:	



Medication #3

Name of Medication/Dosage/Schedule Taken:	Additional Notes:
Date/Time Medication Ordered: Dr's name who ordered it: Kind of medication: (narcotic, etc.)	(Doctor and nurse comments, visiting times for family and friends, patient's general health/reactions, questions for the doctor, 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:	