Guardian Light
quality care services

PHYSICIAN VISIT & FOLLOW-UP TRACKING RECORD

Guardian Light Quality Care Services • Physician visits, orders and follow-up

Client name: _____ **Date of birth:** _____ **Site / room:** _____ **Health care #:** _____ **Record period from:** _____

Allergies: _____ **Guardian / SDM:** _____ **Guardian phone:** _____ **Preferred hospital:** _____ **to:** _____

Date	Visit type	Physician / clinic	Reason for visit / concerns raised	Findings / diagnosis	New orders & medication changes	Follow-up required / next appt.	Notified	Staff initials
dd/mm/yy	*see codes*	*name & specialty*	*symptoms, questions from team*	*what the physician said*	*dose, start/stop dates, tests*	*date, time, referral*	*see codes*	

Visit type: R Routine / annual F Follow-up U Urgent / same-day S Specialist V Virtual / phone W Walk-in clinic ER Emergency dept. H Home visit

Notified: SV Supervisor RN Nurse G Guardian / family PH Pharmacy MAR MAR updated CP Care plan updated

Record every physician contact on the day it happens. Bring this record and the current MAR to each appointment. New orders must be in writing (or read back and confirmed) and the MAR updated before the next dose. Report urgent findings to the supervisor immediately.

Staff completing (print / sign): _____ **Date / time:** _____ **Reviewed by supervisor / date:** _____

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Care team, upcoming appointments and outstanding follow-up

Client name: _____ **Date of birth:** _____ **Site / room:** _____ **Health care #:** _____ **Record period:** _____

CARE TEAM CONTACTS

Role	Name	Phone	Fax / clinic
Family physician			
Psychiatrist			
Specialist:			
Specialist:			
Nurse practitioner			
Pharmacy			
Dentist			
After-hours / on-call			

UPCOMING APPOINTMENTS

Date	Time	With (physician / clinic / location)	Transport & escort	Booked by
			☐ Booked ☐ Confirmed	
			☐ Booked ☐ Confirmed	
			☐ Booked ☐ Confirmed	
			☐ Booked ☐ Confirmed	
			☐ Booked ☐ Confirmed	
			☐ Booked ☐ Confirmed	
			☐ Booked ☐ Confirmed	
			☐ Booked ☐ Confirmed	

OUTSTANDING REFERRALS, TESTS & RESULTS

Referral / test / lab work	Ordered by	Date requested	Appointment / test date	Result received	Result / outcome summary	Shared with physician
				☐ Yes date: ____		☐ Yes ☐ N/A
				☐ Yes date: ____		☐ Yes ☐ N/A
				☐ Yes date: ____		☐ Yes ☐ N/A
				☐ Yes date: ____		☐ Yes ☐ N/A
				☐ Yes date: ____		☐ Yes ☐ N/A
				☐ Yes date: ____		☐ Yes ☐ N/A

Keep contact details current. Cancelled or missed appointments must be rebooked and noted in the visit log with the reason. Confirm transport and an escort at least 24 hours before each appointment.

Staff completing (print / sign): _____ **Date / time:** _____ **Reviewed by supervisor / date:** _____