



ON CALL PATIENT RECORD

Physician:			Patient's Name: <input type="checkbox"/> M <input type="checkbox"/> F		
Nurse:			DOB: Y M D		
Health Centre:			Nunavut Health #		
Date: Y M D	Time: AM PM	Length of Call (in min.)	Home Community:		
HISTORY _ Hx of Present Illness _ Past Medical History _ Social History			Medications:		
			Allergies:		
			Immunizations: To date for age? Y <input type="checkbox"/> N <input type="checkbox"/>		
REPORTED FINDINGS: _ Physical Exam _ Lab _ Xray			Temp:	R.R.	
			B.P.	H.R.	
			O ₂ Sats: (Room Air) _____ %	O ₂ Sats: (Supp. O ₂) ___l/min. ___ %	
ASSESSMENT & PLAN:					
Signature					



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				_____ %	___ l/min. ___ %
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