



**COMMUNITY TRIP REPORT – NORTHERN MEDICAL UNIT
KIVALLIQ REGION – NUNAVUT**

FAX TO 204-789-3959 WHEN COMPLETED

NAME: _____ **COMMUNITY:** _____

- Family/General Practitioner
- Medical Specialist Specialty: _____
- Resident Specialty: _____ Family Medicine
- Audiology
- Other Specify: _____

Accompanied By: _____
(Name and Function)

ARRIVAL				DEPARTURE					
Time:	hr	Day	Mo.	Year	Time:	hr	Day	Mo.	Year

NUMBER OF PATIENTS SEEN IN ALL SETTINGS			
Children < 16 years	Adults ≥ 16 years	Prenatal	TOTAL

APPROXIMATE NUMBER OF CHARTS REVIEWED				
Rx Renewal	Lab / Diagnostic Imaging Review	Case Management	Other	TOTAL

NUMBER OF ELECTIVE REFERRALS MADE:

To Medical Specialists: (please identify by specialty) _____

To Community Resource Programs: (please identify program) Comments:

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HEALTH CARE FACILITIES VISITED: Personal Care Home Long-Term Care Facility Hospice

NUMBER OF HOME VISITS MADE:

NUMBER OF PATIENTS SEEN:

NUMBER OF EMERGENCY EVACUATIONS:

Did you accompany: Yes Number _____ No

Reason(s) for evacuation(s): _____

CONTINUING EDUCATION:

CHART REVIEW: Yes No With: Nurse-in-Charge Other Staff

INSERVICE HELD: Yes No Topic: _____

Audience: _____ N/A

COMMUNITY EDUCATION:

Topic: _____

Audience: _____

COMMUNITY ACTIVITIES: School Visit TV/Radio Meet with Hamlet Mayor & Council

Meet with Health Committee Meet with Home & Community Care Other Agencies

Reason for Meeting/Topic of Discussion: _____

COMMENTS:

For Office Use Only

Date Received by Northern Medical Unit: _____

Program Coordinator's Review:

Followup required: Yes No Letter Dictated: Yes Date: _____ No

Copy Sent: Yes To: DHSS KIS Other: _____ No