**PATIENT LABEL**

|  |  |  |  |
| --- | --- | --- | --- |
| Resident Name: |  | Sex: |  |
| PHN: |  | DOB: |  |
| Date of Call: |  | Time of Call: |  |
| Practitioner on Call: |  | Fax #: |  |
| MRP: |  | Fax #: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MOST Designation: |  | eGFR/Creatnine |  | HR: |  |
| Allergies: |  | BP: |  | Temp: |  |

|  |  |
| --- | --- |
| **S**  Clinical Situation |  |
| **B**  Clinical Information and Background |  |
| **A** Clinical Issue or Assessment |  |
| **R**  Recommendation  Requests |  |

Nurse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Practitioner Response:**