PATIENT INFORMATION FORMS

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Hermanus

talk2@hermanus.co.za
www.talk2.co.za

LOGO

DR. NAME

QUALIFICATIONS

Speciality

Practice No. 000000000000

PATIENT DETAILS	MEDICAL AID DETAILS
Surname:	Gap Cover: Y ☐ N ☐
Full Names:	Main Member Name:
Title:	Main Member Surname:
D.O.B.	Main Member ID Number:
ID Number:	Medical Aid:
Marital Status:	Plan:
Spouse's Name:	Medical Aid Number:
Spouse's ID Number:	Patient Dependant Code:
Occupation:	**NEXT OF KIN**
Home Address:	Name & Surname:
Post Code:	Relationship to Patient:
Postal Address:	Address:
Post Code:	Post Code:
Tel: (H) (W)	Tel: (H) (W)
Cell Phone:	Cell Phone:
Email:	Email:

GENERAL PRACTITIONER	FRIEND/RELATIVE AT A DIFFERENT ADDRESS
GP Name:	Name & Surname:
Referred by:	Relationship to Patient:
Telephone:	Address:
Email:	Post Code:
Address:	Tel: (H) (W)
Post Code:	Email:

A typical form used by Medical Specialists where a patient has been referred to them by a GP.

PERSON RESPONSIBLE FOR ACCOUNT

Full Name:	Home Phone:
Address:	Work Phone:
Post Code:	Cell phone:
Occupation:	Employer:

- I have been informed that this practice does not charge the rates that my Medical Aid may have decided upon.
- My Medical Aid may or may not cover all the fees charged by this practice.
- I am fully responsible for payment and should I not pay timeously, I will be liable for debt recovery & legal costs.

I hereby confirm that the information I supplied is true and that I am hereby responsible for any false information provided.

I, the undersigned, hereby choose my above address as my domicilium citandi et executandi for all purposes under this agreement. I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS MENTIONED ABOVE. I CONFIRM THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT.

Signature ..... Date .....

Space for additional legal clauses if requried:
E.g. statements such as "In the event of any legal action being instituted against me for recovery of any amount whatsoever, I shall be liable for all legal costs including admin costs and a x% admin fee on each installment paid. If the matter is defended, I will be liable for legal costs incurred on an attorney/client scale."
The policy of the operation of this practice has been explained to me verbally.
Once my account has been handed over there will be no further correspondence entered into with the practice.
The National Credit Act 34 of 2005 is not applicable to this claim.

PATIENT TERMS AND CONDITIONS

Please read this agreement carefully, and sign if you fully AGREE & UNDERSTAND these terms & conditions.

INFORMED CONSENT

I understand that I have the right to ask my doctor to explain and disclose medical information to me before I agree to a medical procedure or treatment, including the following:

- different treatment options available to me,
- common and serious side effects of specific treatment options
- the benefits, risks, costs and consequences associated
- details of the diagnosis and prognosis, and the likely p untreated;
- any uncertainties regarding the diagnosis;
- how and when my condition and any side effects will be monitored or re
- the name of the doctor who will have overall responsibility for the treatment;
- that I have the right to seek a second opinion at any time.

GENERIC MEDICINE

I understand and acknowledge that my Medical Scheme may insist that I substitute medicine that appears on my prescription with its generic equivalent. It is within my doctor's sole discretion whether or not to allow for the generic substitution of my medicine and no substitution may take place where the doctor has written 'no generic substitution' on my prescription.

DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize:

- the use and disclosure of my medical information to any relevant specialist as my primary doctor may see fit.
- that a copy of my medical record will be kept by my doctor on file.
- the disclosure of relevant medical information to my Medical Aid - will typically include diagnoses & ICD10 codes.
- the practice to have access to my hospital records, radiology & laboratorial results.

PRIVACY OF MEDICAL INFORMATION

I understand that this practice has implemented reasonable security measures to guard against the unauthorized disclosure of my patient information, and that I may revoke my authorization in writing at any time.
My patient information may be disclosed by this practice in response to a specific request by a law enforcement agency, subpoena, court order, or as required by law.

PAYMENT OF MEDICAL COSTS

I acknowledge that:

- I have been informed that this practice does not necessarily charge the rates that my Medical Aid may have decided upon.
- My Medical Aid may or may not cover all the fees charged by this practice.
- I am fully responsible for payment and should I not pay timeously, I will be liable for debt recovery & legal costs.

MEDICAL CERTIFICATES ('SICK NOTE')

I hereby acknowledge that I understand that although I am entitled to ask for a medical certificate from my doctor, he/she is under no obligation to issue such a certificate. My diagnosis will only be disclosed on the certificate provided I have given my consent, and the decision who I want to show the certificate to is at my sole decision.

PRE-AUTHORISATION

I am fully aware that if a procedure requires hospitalization, I am responsible to ensure that my Medical Aid provides the required permission and covers the financial cost of the procedure BEFORE I undergo the procedure. My Medical Aid may contact my doctor to discuss the need, or to ask for a motivation, for the procedure and I accept responsibility for the costs thereof.

GENERAL

I hereby confirm that:

- I have freely chosen this practice to consult with.
- I am aware of the fact that the availability of my doctor is generally limited to office hours and consulting times.
- I am under the obligation to inform the practice of changes to my personal, medical and/or financial information.
- I hereby understand that my doctor has the right to change his/her mind about a medical decision at any time.
- I have had an opportunity to review these terms and conditions and that this form accurately reflects my wishes.
- I have read and understand each of the terms and conditions contained in this agreement.
- I have a right to inspect and/or copy these terms and conditions.
- I am signing these terms and conditions voluntarily.
- I have been informed that should my medical scheme not settle the account of the practice in full, I hereby consent to authorize the practice to challenge my medical scheme at the Council for Medical Schemes on my behalf.

Reverse of form

PASIËNT TERME EN VOORWAARDES

Lees asseblief hierdie ooreenkoms noukeurig en teken as jy dit heeltemal verstaan en met hierdie terme en voorwaardes saamstem.

INGELIGTE TOESTEMMING

Ek verstaan dat ek die reg het om my dokter te vra om die mediese prosedure en behandeling aan my te verduidelik voordat ek instem tot enige mediese prosedure of behandeling, insluitend die volgende:

- die verskillende behandeling-opsies wat vir my beskikbaar is;
- e en ernstige newe-effekte van 'n spesifieke behandeling;
- 's, koste en gevolge wat verband hou met elke opsie;
- e diagnose en prognose, en die waarskynlike prognose as die el word nie;
- e ten opsigte van die diagnose;
- meer my toestand en enige newe-effekte gemonitor of her-evalueer sal word;
- Die naam van die dokter wie verantwoordelik vir die behandeling sal wees;
- dat ek die reg het om 'n tweede opinie te enige tyd in te win.

GENERIESE MEDISYNE

Ek verstaan en erken dat my mediese skema kan aandring dat ek medisyne wat op my voorskrif verskyn met 'n generiese ekwivalent vervang. Dit is my dokter se alleenreg om nie toe te laat dat generiese vervanging van my medisyne plaasvind wanneer die dokter op my voorskrif geskryf het: "Geen generiese vervanging".

MEDIESE INLIGTING

Ek magtig:

- die gebruik en bekendmaking van my mediese inligting aan enige relevante spesialis indien my primêre dokter dit nodig ag.
- dat 'n afskrif van my mediese rekord deur my dokter op lêer gehou word.
- die bekendmaking van relevante mediese inligting aan my mediese fonds – wat diagnoses & ICD10 kodes sal insluit.
- die praktyk om toegang te hê tot my hospitaal rekords, radiologie en laboratorium uitslae.

PRIVAATHEID VAN MEDIESE INLIGTING

Ek verstaan dat hierdie praktyk redelike sekuriteitsmaatreëls in plek het om die ongemagtigde bekendmaking van my pasiënt inligting te beskerm, en dat ek my magtiging te eniger tyd skriftelik kan herroep.
My pasiënt inligting kan deur hierdie praktyk openbaar gemaak word op spesiale versoek deur 'n wetstoepassingsagentskap, dagvaarding, hofbevel, of die wet.

BETALING VAN MEDIESE KOSTE

Ek erken dat:

- ek ingelig is dat hierdie praktyk nie noodwendig die tariewe hef soos deur my mediese fonds bepaal.
- my Mediese Fonds nie noodwendig al die fooie betaal wat deur hierdie praktyk gehef word nie.
- ek ten volle verantwoordelik is vir die betaling en sou ek nie betyds betaal nie, ek aanspreeklik gehou sal word vir die skuld insameling en regskoste daaraan verbonde.

MEDIESE SERTIFIKATE ('SIEK NOTA")

Ek erken hiermee dat ek verstaan dat, alhoewel ek geregtig is om te vra vir 'n mediese sertifikaat van my dokter, hy/sy onder geen verpligting is om so 'n sertifikaat uit te reik nie. My diagnose slegs bekend gemaak sal word op die sertifikaat indien ek toestemming daartoe gee en ek mag op my eie diskresie besluit aan wie ek die sertifikaat wil openbaar.

VOORAFMAGTIGING

Ek is ten volle bewus daarvan dat as 'n prosedure hospitalisasie vereis ek verantwoordelik is om te verseker dat my mediese fonds die nodige toestemming verleen en finansiële koste van die prosedure sal dek voordat ek die prosedure ondergaan. My mediese fonds kan my dokter kontak om hierdie rede, of om motivering aan te vra vir die prosedure, en ek aanvaar verantwoordelikheid vir die kostes hiervan.

ALGEMEEN

- ek bevestig dat :
- ek hierdie praktyk vrylik gekies het om mee te raadpleeg.
- ek bewus is dat my dokter oor die algemeen slegs beskikbaar is gedurende kantoorure en raadgewende tye.
- ek verpligtig is om die praktyk in te lig van veranderinge m.b.t. my persoonlike, mediese en/of finansiële inligting.
- ek verstaan hiermee dat my dokter die reg het om sy/haar opinie oor 'n mediese besluit te enige tyd kan verander.
- ek het 'n geleentheid om hierdie terme en voorwaardes te hersien en dat hierdie vorm my wense weerspieël.
- ek elkeen van die terme en voorwaardes gelees en verstaan het, soos vervat in hierdie ooreenkoms.
- ek 'n reg het om hierdie terme en voorwaardes te inspekteer en/ of 'n afskrif aan te vra.
- ek hierdie terme en voorwaardes vrywillig onderteken.
- ek ingelig is dat, indien my mediese skema nie die rekening van die praktyk ten volle vereffen nie, ek hiermee instem dat die praktyk gemagtig is om namens my my mediese skema aan te gee by die Raad vir Mediese Skemas.

By signing this document you legally bind yourself to the terms and conditions contained herein.
Deur die ondertekening van hierdie dokument verbind jy jouself wettig aan die terme en voorwaardes hierin vervat.

Signature: Date:
Handtekening ..... Datum .....

LOGO

DR NAME
QUALIFICATIONS

SPECIALITY

PR. NO. 000000000000000

A typical form used by GPs.

PATIENT DETAILS	MEDICAL AID DETAILS
Surname:	Gap Cover: Y ☐ N ☐
Full Names:	Main Member Name:
Title:	Main Member Surname:
D.O.B.	Main Member ID Number:
ID Number:	Medical Aid:
Marital Status:	Plan:
Spouse's Name:	Medical Aid Number:
Spouse's ID Number:	Patient Dependant Code:
Occupation:	**NEXT OF KIN**
Home Address:	Name & Surname:
Post Code:	Relationship to Patient:
Postal Address:	Address:
Post Code:	Post Code:
Tel: (H) (W)	Tel: (H) (W)
Cell Phone:	Cell Phone:
Email:	Email:

FRIEND/RELATIVE AT A DIFFERENT ADDRESS

Name:	Surname:
Relationship to Patient:	
Address:	
Post Code:	
Tel: (H)	Tel: (W)
Email:	

PERSON RESPONSIBLE FOR ACCOUNT

Full Name:	Home Phone:
Address:	Work Phone:
Post Code:	Cell phone:
Occupation:	Employer:

Note: I am personally responsible for payment and not my medical aid. In the event of divorce the parent accompanying the minor is responsible for settlement of the account. In the event of any legal action being instituted against me for recovery of any amount whatsoever, I shall be liable for all legal costs including admin costs and a 20% admin fee on each installment paid. If the matter is defended, I will be liable for legal costs incurred on an attorney/client scale. The policy of the operation of this practice has been explained to me verbally. Once my account has been handed over there will be no further correspondence entered into with the practice. All correspondence will be with Absolute Debt Solutions or LEXMED. The National Credit Act 34 of 2005 is not applicable to this claim.

I, the undersigned, hereby choose my above address as my domicilium citandi et executandi for all purposes under this agreement. I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS MENTIONED ABOVE. I CONFIRM THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT.

Signature ..... Date .....

LOGO

DR NAME

QUALIFICATIONS

SPECIALITY

PR. NO. 000000000000000

PATIENT DETAILS

Surname:	First Names:
Date of Birth:	Age.:
Physical Address:	
	Postal Code:
Referred by:	Contact Tel No:
Patient's GP:	Contact Tel No:
Patient's Paediatrician:	Contact Tel No:

PARENT DETAILS (or Primary caregiver)

Surname of Mother:		First name
Telephone No: Home:	Work:	Cell:
E-mail Address:		
Occupation:		Employer:
Surname of Father:		First name
Telephone No: Home:	Work:	Cell:
E-mail Address:		
Occupation:		Employer:

Preference for receiving confidential reports (please provide details below): E-mail:☐ Fax:☐ Post☐

Email address/Fax No/Postal Address:

PERSON RESPONSIBLE FOR ACCOUNT

Surname:	First Names:	
ID No:	Relationship to Patient:	Gap Cover: Y☐ N☐
Contact Details (if different from above): E-mail:		
Telephone No: Home:	Work:	Cell:
Home Address:		
		Postal Code:
Postal Address:		
		Postal Code:
Medical Aid Scheme:		
Medical Aid No:	Dependant No:	
Main Member Surname:	First Name:	
Main Member ID No:	Main member Occupation:	
Employer:	Work Address:	
		Postal Code:

Please note: It is the responsibility of the parents/caregivers to ensure the details on this form are correct at all times. Should any of the above details change kindly amend or request an updated form. Thank you.

Space for additional legalclauses if requried:
E.g. statements such as "In the event of any legal action being instituted against me for recovery of any amount whatsoever, I shall be liable for all legal costs including admin costs and a x% admin fee on each installment paid. If the matter is defended, I will be liable for legal costs incurred on an attorney/client scale."
The policy of the operation of this practice has been explained to me verbally.
Once my account has been handed over there will be no further correspondence entered into with the practice.
The National Credit Act 34 of 2005 is not applicable to this claim.

Please Note: I, the undersigned, am aware that this practice does not charge the rates that the Dept of Health has unilaterally determined for doctors and which is known as the Reference Price List (RPL). I also am aware that this practice MAY charge up to a rate of 3 times the RPL. I acknowledge that I am fully responsible for the payment of services rendered by the doctor should medical aid not pay in full.
I hereby confirm that the information I supplied is true and that I am hereby responsible for any false information provided.

Signed: _____

Date: _____

Print Name: _____

LOGO

DR NAME

QUALIFICATIONS

SPECIALITY

Practice Number 000000000

File No:

Patient Details:

Surname:		First Names:	
Title:	Date of Birth:	ID No.:	Gap Cover: Yes ☐ No ☐
Tel (H):	Tel (W):	Cell:	
Email:			
Home Address:			
			Postal Code:
Occupation:		Employer:	
Work Address:			
			Postal Code:

Details of Spouse:

Name & Surname:		
ID No:	Work Tel:	Cell:

Person responsible for account:

Surname:	First Names:
Occupation:	Employer:
Home Address:	
	Postal Code:
Postal Address:	
Postal Code:	E-mail:

Nearest Family/Friend:

Surname:		First Names:
Tel (H):	Tel (W):	Cell:
Email:		
Home Address:		
		Postal Code:

Next of Kin:

Surname:		First Names:
Tel (H):	Tel (W):	Cell:
Email:		
Home Address:		
		Postal Code:

Medical Aid Details:

Fund:	Medical Aid No:
Member's names:	Option/Plan:
Dependant Code:	Gap Cover: Yes ☐ No ☐

Referred By:

Name:	Tel No:
Address	
Postal Code:	E-mail:

In the event of any legal action being instituted against me for recovery of any amount whatsoever, I shall be liable for all legal costs incurred on an attorney and client scale including admin costs and a 20% receipting fee. If the matter should be defended, I will be liable for legal costs incurred on an attorney client scale. The National Credit Act 34 of 2005 is not applicable to this claim.

Please Note: I, the undersigned, am aware that this practice does not charge the rates that the Dept of Health has unilaterally determined for doctors and which is known as the Reference Price List (RPL). I also am aware that this practice MAY charge up to a rate of 2 times the RPL. I acknowledge that I am fully responsible for the payment of services rendered by the doctor should medical aid not pay in full.
I hereby confirm that the information I supplied is true and that I am hereby responsible for any false information provided.

....
Signature Date

LOGO

DR NAAM

KWALIFIKASIES

SPESIALITEIT

For Office Use / Vir Kantoor Gebruik

Account No/Rekening Nr _____ Date/Datum: _____

PATIENT DETAILS / BESONDERHEDE VAN PASIËNT

Surname / Van _____ Initials/Voorletters _____ Title/Titel _____

First Name / Voornaam _____ Gender/Geslag Male/Man Fem/Vrou

ID No./Nr. _____ Date of Birth/Geboortedatum _____

Physical Address/Fisiese Adres _____

_____ Code/Kode _____ Tel: (____) _____

Postal Address/Posadres _____

_____ Code/Kode _____ Cell/Sel: _____

Occupation / Beroep _____

Employer/Werkgewer _____ Tel: (____) _____

Business Address/Werksadres _____ Code/Kode _____

Next of Kin/Naasbestaande _____ Relationship/Verwantskap _____ Tel: (____) _____

Gap Cover/Gapingsdekking Yes/Ja☐ No/Nee☐ Policy No/Polis nr:_____

MEDICAL AID DETAILS / MEDIESE FONDS BESONDERHEDE *(please complete all the fields/voltooi asb alle velde)*

Medical Aid Name/Naam van Mediese Fonds _____

Medical Aid Number/Mediese Fondsnommer _____

Medical Aid Plan/Mediese Fonds Plan _____ Dependant No/Afhanklike Nr _____

Gap Cover/Gapingsdekking Yes/Ja☐ No/Nee☐ Policy No/Polis nr:_____

MEMBER/PERSON RESPONSIBLE FOR PAYMENT / LID/PERSOON VERANTWOORDELIK VIR BETALING

Name/Naam _____ Tel: (____) _____ Cell/Sel: _____

ID No./Nr. _____ Date of Birth/Geboortedatum _____

Postal Address/Posadres _____

_____ Code/Kode _____

Occupation / Beroep _____

Employer/Werkgewer _____ Tel: (____) _____

Business Address/Werksadres _____ Code/Kode _____

E-mail address/E-pos adres: _____

REFERRING DOCTOR / VERWYSENDE GENEESHEER

Surname/Van _____ First Name/Voornaam _____

Practice Location/Praktyk Ligging _____

General Practitioner / Algemene Praktisyn (If different than referring Doctor / Indien verskil van verwysende Geneesheer)

Surname/Van _____ First Name/Voornaam _____

PLEASE NOTE / NEEM ASSEBLIEF KENNIS

This practice charges in excess of NHRPL tariffs (Medical Aid Rates). The following is applicable to ALL patients:
A fixed fee of RXXX is payable for 1st consultations and RXXX for follow-up visits. This excludes procedures/consumables.
Hierdie praktyk se fooie oorskry die NHRPL tariewe (Mediese Fonds). Die volgende is van toepassing vir ALLE pasiënte:
'n Vaste fooi van RXXX is betaalbaar met 1ste konsultasies en RXXX met opvolg besoeke. Prosedures/voorraad word uitgesluit by bogenoemde.

SEE REVERSE FOR CONDITIONS OF SERVICE / SIEN KEERSY VIR VOORWAARDES VIR DIENSLEWERING

Example of a form used by a Psychiatrist.

PATIENT INFORMATION
Kindly furnish details

Date of First Visit: _____

PATIENT'S DETAILS

Surname:	Name:
Date of Birth:	Home Tel. No.:
Address:	
	Postal Code:
Name of School:	
Teacher's Name:	Grade at School:

MOTHER'S DETAILS

Surname:		Name:
Date of Birth:	Home Tel:	Cell:
Address: (if different from above):		
Employer:		Work Tel:

FATHER'S DETAILS

Surname:		Name:
Date of Birth:	Home Tel:	Cell:
Address: (if different from above):		
Employer:		Work Tel:

GENERAL

E-mail Address (for accounting purposes):

SIBLINGS

	NAMES	AGES
Brothers:		
Sisters		

REFERRED TO DR YOUNG BY:

Name:	
Address:	
Tel:	Cell:
E-mail:	

MEDICAL AID

Fund:	Medical Aid No:	
Main Member:	Option/Plan:	
Dependant Code:	Medical Aid Tel No:	Gap Cover: Yes ☐ No ☐

Please allow my secretary to make a copy of your medical aid card.

NOTE: I am personally responsible for payment and not my medical aid. In the event of Divorce the parent accompanying the minor is responsible for settlement of the account. In the event of any legal action being instituted against me for recovery of any amount whatsoever, I shall be liable for all legal costs including admin costs and a 20% admin fee on each installment paid. If the matter is defended, I will be liable for legal costs incurred incurred on an attorney/client scale.
The policy of the operation of this practice has been explained to me verbally. Once my account has been handed over there will be no further correspondence entered into with the practice. All correspondence will be with Absolute Debt Solutions or LEXMED.
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Please Note: I, the undersigned, am aware that this practice does not charge the rates that the Dept of Health has unilaterally determined for doctors and which is known as the Reference Price List (RPL). I also am aware that this practice MAY charge up to a rate of 3 times the RPL.
I hereby choose my above address as my domicilium citandi et executandi for all purposes under under this agreement. I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS MENTIONED IN THIS DOCUMENT. I CONFIRM THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT.

....
Signature Date

LOGO

DR NAME

QUALIFICATIONS

SPECIALITY

PR. NO. 000000000000000

Surname:	
Full Names:	
Title:	
D.O.B.	
Marital Status:	
ID Number:	
Occupation:	
Employer:	
Address:	
Home Phone:	
Work Phone:	
Cell Phone:	
Email Address:	
Height (m):	
Weight (kg):	
Time:	
BMI:	

NEXT OF KIN

Full Name:	
Relationship to Patient:	
Address:	
Home Phone:	
Work Phone:	
Cell Phone:	

DOCTOR

Referring	
Family	

MEDICAL AID SCHEME

Name:	
Membership number:	
Member ID Number:	
Plan/Scheme:	
Authorisation Number:	
Dependant number/Code:	

PERSON RESPONSIBLE FOR ACCOUNT

(If same as above, do not complete this section)

Full Name:		Home Phone:	
Address:		Work Phone:	
		Cell phone:	
Occupation:		Employer:	

TERMS AND CONDITIONS

PLEASE NOTE
This practice charges in excess of NHRPL tariffs (Medical Aid Rates). The following is applicable to ALL patients:
A fixed fee of RXXX is payable for 1st consultations and RXXX for follow-up visits. This excludes procedures/consumables.

SEE REVERSE FOR CONDITIONS OF SERVICE

Space for additional legalclauses if requried:
E.g. statements such as "In the event of any legal action being instituted against me for recovery of any amount whatsoever, I shall be liable for all legal costs including admin costs and a x% admin fee on each installment paid. If the matter is defended, I will be liable for legal costs incurred on an attorney/client scale."
The policy of the operation of this practice has been explained to me verbally.
Once my account has been handed over there will be no further correspondence entered into with the practice.
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Signature ..... Date .....

LOGO

A form used by a Specialist Physician & Endocrinologist

Date:

Patient Name: _____
ID: _____
Folder No: _____
Tel: _____
Med Aid: _____
Number: _____

Ref Dr: _____

Allergies:

Medications:

Medical / Surgical History:

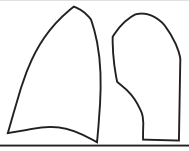
Smoking _____ ETOH_____

Presenting Symptoms:

General Hgt: Wgt: BMI: AC:

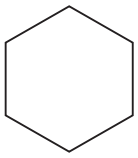
BP: P: RR: Sats:

Chest:



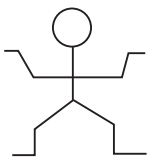
CVS
Heart Sounds: _____ Murmurs: _____
JVP: ____ _____
DP: _____ PT: _____

Abdomen:

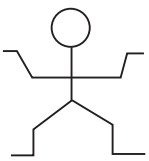


Neuro:
GCS:____/15
Cranial Nerves:
Plantars: L R

Reflexes



Power



Blds:

ECG

Radiology: _____

Diagnosis / Problems:

Management / Plan: