Telephone Message Hospital Forms

Message taken by:	
Date:	Patient Name:
Problem/ Patient Complaint:	Current Medications:
Caller's name if not patient: Relationship to patient:	Other Medical Problems: Allergies:
Phone#	Patient' Age:
Work Phone#	Weight:
Cell Phone#	Pregnant:
From _____am/pm To _____am/pm	Primary Care Physician:
Patient can be reached ☐ at home ☐ on call ☐ at work	

Problem/Patient Complaint (cont. if necessary):	
Medication refill (circle)	Medication:
Pharmacy Name	Phone#