

Follow Up Phone Calls Questionnaire

PatientsName: _____

Date: _____ Time: _____

Encounter Number: _____

If the patient had a follow up appointment with their healthcare provider, how did that appointment go?
Is the patient taking any new medications?
Is the patient receiving any new treatments? Or services ordered?
Is the patient receiving home care? If so, what does the home care consist of?
Barriers:
Resolution/Interventions:

Signature: _____ Date: _____ Time: _____



PT.

MR#/RM.

DR.