

Continuity of Care Patient Follow-up Form		
Patient Name:	MRN:	
Age:	Sex:	Race:
Date of Admit:	Date of Discharge:	
Drug Allergies:		
Referring Service:		
Your Name and Pager Number:		
Reason for Admission/ Hospital Course:		
Past Medical History:		
Significant Labs:		
Medications Prior to Admission:		
Discharge Medications:		
Points which need follow-up:		
Site of Follow-up: <input type="checkbox"/> UDC <input type="checkbox"/> McClennan Banks <input type="checkbox"/> Family Medicine <input type="checkbox"/> Hollings Cancer Ctr <input type="checkbox"/> Other (please specify)		
Date of Follow-up (if known):		
Form sent to:		

