MUNSON HEALTHCARE

Patient Visit Downtime Form

Fill out this form using the downtime report or Cerner read only, if applicable.

Page 1. PATIENT INFORMATION		
Last Name	First Name	Middle Initial
Date of Birth	MRN	Gender ☐Male ☐Female

APPOINTMENT INFORMATION	
Appointment Date & Time	Appointment Type
Attending Provider	Supervising Provider
Reason for Visit	Chief Complaint

VITALS			
Blood Pressure (BP)	BP Source	Pulse	Respirations
O2 Sat	Temp. ☐°C ☐ °F	Temp. Source	Pain Level (1-10)
Wt. ☐ kg ☐lbs.	Ht. ☐cm ☐inches	Other Vitals	
EGA/EDD	Fundal Height	Fetal Heart Rate	Blood Products ☐Accept ☐Refuse
Comments			

HISTORY	
Social, Family & Procedure/Surgical Histories reviewed on downtime report ☐Yes ☐No	
Social History	Tobacco
	Smokeless Tobacco
Family History	
Procedure/Surgical History	
OB/GYN History	

ALLERGIES		
Allergies reviewed on downtime report ☐Yes ☐No	☐No Known Allergies ☐NKDA	
Changes/Additions to Patient Allergies:		
Allergy	Reaction(s)	Category
		☐Food ☐Drug ☐Environment
		☐Food ☐Drug ☐Environment

MEDICATIONS				
Medications reviewed on downtime report ☐Yes ☐No		Preferred Pharmacy:		
Additional medication page attached ☐Yes ☐No				
Medication	Medication Details	Compliance	Prescribing Provider	Script provided
				☐Yes
				☐Yes
				☐Yes
				☐Yes
				☐Yes

COMMENTS

Time	Date	Clinical Staff Name	Signature

Page 2. PATIENT INFORMATION		
Last Name	First Name	Date of Birth

Subjective/ History of Present Illness

Review of Systems

Objective/ Physical Exam

PROBLEMS BEING ADDRESSED THIS VISIT

CHARGES	

ORDERS		
Order Description/Code	Associated Problem/Diagnosis	Paper Script/Req Provided
		☐Yes ☐No ☐N/A
		☐Yes ☐No ☐N/A
		☐Yes ☐No ☐N/A
		☐Yes ☐No ☐N/A
		☐Yes ☐No ☐N/A
		☐Yes ☐No ☐N/A

ASSESSMENT & PLAN

Time	Date	Provider Name	Signature

SUPERVISING PROVIDER COMMENTS			
Time	Date	Supervising Provider Name	Signature

Note: Attach any other printed reports and/or paper document used. Scan in downtime form with this report if used.