# TELEPHONE TRIAGE FORM

Taken by: ______________________________ Doctor: _________________________

Date: __________________________________

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Patient Name ______________________________________________________________

Phone Number _________________________ _________________________________
Home Work

Allergies _________________________________________________________________

Date Last Seen _________________________ Date Last Triage _________________

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## Symptoms

Date of Onset _____________________________________________________________

Symptoms Fever ____________________ Pain ____________________________

Location __________________________________________________________________

Other _____________________________________________________________________

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Change in health status since last visit (hospitalizations, changes in meds, pregnancy)
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Actions Taken _____________________________________________________________

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_______ Patient instructed to follow-up if symptoms persist.