

FOLLOW-UP CONSENT



Eve Surgical Center
Medical Corporation

Patient Name: _____ Date: _____

In keeping with our goal to provide high quality medical care, Eve Surgical Center routinely calls to check on your progress 3-4 days following surgery. We realize privacy is also important. Therefore, we request your approval.

Please initial one of the following:

_____ 1. Yes, you may call me at home/ work (daytime number) (_____) _____
Initial

May we leave a message at this number? [] Yes [] No

_____ 2. No, do not call me (except in case of an emergency).
Initial

Please do not write below this line (for office use only)

Patient contacted: Date ____/____/____

Time: _____ AM/PM

By: _____

Left Message: _____
Date Time By

Left Message: _____
Date Time By

Status:

Bleeding

Cramps

Fever

Mental Status

Ut. Mas., Br. C., Meds.

F/U exam reminder

Comments _____

DOS: ____/____/____
1st/ 2nd/ 3rd Trimester _____ wks

EAB/ TAB Dx: _____

Initial: _____

Logged by: Initial

Date: _____