

Your
Hospital's
Logo
Here

CARDIAC CATHETERIZATION / INTERVENTIONAL PHONE FOLLOW-UP

PATIENT IDENTIFICATION

PATIENT NAME:

PHONE NUMBER:

1. After your procedure, did you experience any:

(Mark with an "X" on line-graph)

None

Mild

Moderate

Severe

CHEST PAIN |-----|

LUMPS or SWELLING |-----|

PROCEDURE SITE PAIN |-----|

BLEEDING |-----|

PROCEDURE LEG PAIN |-----|

NUMBNESS |-----|

2. Did you have to return to your physician because of procedure related problems?

YES

NO

If "YES", describe: _____

3. Were you made to feel at ease during your procedure?

YES

NO

4. Were your pre-procedure instructions helpful?

YES

NO

5. Were your post-procedure instructions helpful?

YES

NO

6. How would you rate your Cardiac Catheter Lab care?

(Mark with an "X" on line-graph)

WORST

BEST

0 1 2 3 4 5
CATH LAB CARE |-----|

Additional Comments: _____

7. Is there anything else you want to relate about your experience?

CONCERN / COMPLAINT

WHO DID CALLER NOTIFY

8. Indicate if patient was reached on 1st or 2nd attempt, if patient couldn't be reached, if patient was referred to an MD for problems, etc:

OUTCOME OF (ATTEMPTED) COMMUNICATION WITH PATIENT

DATE / TIME

RN SIGNATURE / TITLE:

DATE:

DATA COLLECTION SHEET - Not Permanent Part of Chart