

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

**DEPARTMENT OF NEUROSURGERY
CLINICAL PLANNING SHEET**

Patient Name: _____ History # _____ Date of Service _____

Presenting (complaint) Diagnosis: _____

Providing Physician: _____

Referring Physician: _____

Family Physician: _____

- New patient
- Return patient
- Postop F/U
- Amb. Care Svcs.

FILMS:

- None UVA Outside _____
- CD Films
- Returned to patient Neurorad GK _____

HPI:

Meds/PMHx:

Exam:

PLAN:

	YES	NO
REGISTRATION: _____	<input type="checkbox"/>	<input type="checkbox"/>
CLINIC ARRIVAL: _____	<input type="checkbox"/>	<input type="checkbox"/>
ROOM ARRIVAL: _____	<input type="checkbox"/>	<input type="checkbox"/>
DEPARTURE: _____	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date _____