TEAMHealth®

PHYSICIAN IN-PATIENT SERVICES/CODE BLUE FORM

Patient's Name: _____

Hospital Medical Record Number: _____Date of Service: _____

Diagnosis: _____

❑ **Critical Care** **Critical Care Time:_____min.**
(Critical Care time **does not** include time for separately billed procedures).

❑ **Procedures Performed**

❑ CPR
❑ Endotracheal Intubation
❑ Central Line Placement
❑ Ventilator Management
❑ Tube Thoracostomy
❑ Injury Assessment
❑ Restraint Evaluation
❑ Psychiatric Evaluation
❑ Emergency Delivery
❑ Feeding Tube Replacement
❑ Laceration Repair
❑ Medical Assessment Only

Other:_____

Consulting/Referring Physician's Name (Please Print): _____

ED Physician's Name (Please Print):_____

ED Physician's Signature:_____

****INFORMATION THAT MUST BE INCLUDED WITH THIS SHEET****

PLEASE MAKE SURE THAT YOU HAVE MADE A NOTE IN EPIC/MEDITECH ON THE PATIENT'S CHART. IF YOU ARE UNABLE TO DO THIS, PLEASE USE A DOWN-TIME PROGRESS NOTE AND INCLUDE IT WHEN YOU FAX THIS FORM.

PLEASE FAX TO NANCY WINDSOR AT 1-865-560-7136.

IF YOU HAVE ANY QUESTIONS, PLEASE DIRECT THEM TO NANCY AT Nancy_Windsor@teamhealth.com, you may also call or text her at 1-865-500-1364.