#### Appointments/Meetings Log



Use this form to keep track of meetings and appointment you have about your child's health care.

Call/Meeting	Date/Time	Name of Person/Agency	Contact Information	What was Discussed/Decided

pediatric palliative care coalition°	Child's Name	Date of Birth	/	/
	Date Last Revised:			

# Appointments

Date/Time	Hospital	Doctor/Specialty	Questions/Results/Comments/Follow-up

pediatric palliative care coalition°

**Child's Name** 

Date of Birth

/

### Hospital Stays

pediatric palliative care coalition°



Date of Admission/ Date of Discharge/	Date of Admission/ Date of Discharge/
Reason for Admission	Reason for Admission
Hospital	Hospital
AddressStateZip	Address City State Zip
Phone	Phone
Doctor/Surgeon	Doctor/Surgeon
Type of Surgery/Procedure	Type of Surgery/Procedure
Outcome	Outcome
Date of Admission/ Date of Discharge/	Date of Admission/ Date of Discharge/
Reason for Admission	Reason for Admission
Hospital	Hospital
AddressStateZip	Address City State Zip
Phone	Phone
Doctor/Surgeon	Doctor/Surgeon
Type of Surgery/Procedure	Type of Surgery/Procedure
Outcome	Outcome

**Child's Name** 

**Date Last Revised:** 

Date of Birth

### Hospital Stays

pediatric palliative care coalition°



Date of Admission/ Date of Discharge/	Date of Admission/ Date of Discharge/
Reason for Admission	Reason for Admission
Hospital	Hospital
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Doctor/Surgeon	Doctor/Surgeon
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Outcome	Outcome
Date of Admission/ Date of Discharge/	Date of Admission/ Date of Discharge/
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Doctor/Surgeon	Doctor/Surgeon
Type of Surgery/Procedure	Type of Surgery/Procedure
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**Child's Name** 

**Date Last Revised:** 

Date of Birth

### Hospital Stays

pediatric palliative care coalition°



Date of Admission/ Date of Discharge/	Date of Admission/ Date of Discharge/
Reason for Admission	Reason for Admission
Hospital	Hospital
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Date of Admission/ Date of Discharge/	Date of Admission/ Date of Discharge/
Reason for Admission	Reason for Admission
Hospital	Hospital
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Doctor/Surgeon	Doctor/Surgeon
Type of Surgery/Procedure	Type of Surgery/Procedure
Outcome	Outcome

**Child's Name** 

**Date Last Revised:** 

Date of Birth



pediatric palliative care coalition°	Child's Name	Date of Birth / /

**Date Last Revised:** 



Date	Hospital/Medical Facility	Doctor	Admitted?	Results/Comments

pediatric palliative care coalition°	Child's Name	Date of Birth	/	1
	Date Last Revised:			

## Tips for a Good Visit



This information can be helpful for the doctor and others to know.	Notes	
Child's Nickname		
My child is verbal ☐ Yes ☐ No		
My child likes it when you:		
My child does not like it when you:		
·		
If my child does not want to do something, here are things that can help:		
pediatric palliative care coalition°	Child's Name	Date of Birth / /

**Date Last Revised:** 

#### Things to Remember for Next Visit



Date					
pediatric palliative care c	oalition <sup>°</sup>	Child's Name	Date of Birth	/	1

**Date Last Revised:**