Bedside Question & Answer Form

Please fill out this form with any questions or concerns you might have for the doctor or nurse who is taking care of you. Please date and time all questions for the timeliest response possible.

PATIENT

Question/Concern: ____

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Date/Time: **Month/Day/Year**: ________________**Time:**______________

PHYSICIAN / NURSE

Name: ____

Date/Time: **Month/Day/Year**: __________________**Time**:__________________

Response: ____

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Greater Cincinnati **Health Council**

If it involves health, we're involved.

It's OK to ASK Campaign