

## Patient Flow Time Study

In an effort to improve patient flow we are conducting a survey throughout each *point of contact*. As you reach each point of contact the appropriate staff will sign or initial this form before the start of each process. Please double check the time to make this study as accurate as possible, if there are any discrepancies please let us know.

Please return this form back to patient registration after you have been discharged from your providers care and all ancillary tests (X-ray/lab) have been completed.

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Provider: \_\_\_\_\_

HR #: \_\_\_\_\_

Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

### Primary Care Clinic

#### 1) Checked in with Patient Registration

Time: \_\_\_\_\_ Patient Registration Signature: \_\_\_\_\_

#### 2) Screened by Nurse (Vitals)

Time: \_\_\_\_\_ Screening Nurse/Aide Signature: \_\_\_\_\_

#### 3) Placed in room by nurse

Time: \_\_\_\_\_ Screening Nurse/Aide Signature: \_\_\_\_\_

#### 4) Medication Reconciliation/Nurse Assessment

Time: \_\_\_\_\_ Screening Nurse Signature: \_\_\_\_\_

#### 5) Examined by Medical Provider

Time: \_\_\_\_\_ MEDICAL PROVIDER Signature: \_\_\_\_\_

### Laboratory and/or Radiology

#### a) Sent to Lab

Time: \_\_\_\_\_ PC or Lab Staff Signature: \_\_\_\_\_

#### b) Return from Lab

Time: \_\_\_\_\_ PC or Lab Staff Signature: \_\_\_\_\_

#### c) Sent to Radiology (X-Ray/CT Scan/Ultrasound)

Time: \_\_\_\_\_ PC or Radiology Staff Signature: \_\_\_\_\_

#### d) Return from Radiology

Time: \_\_\_\_\_ PC or Radiology Staff Signature: \_\_\_\_\_

#### 6) Patient Discharged from Primary Care

Time: \_\_\_\_\_ MEDICAL PROVIDER/Nurse Signature: \_\_\_\_\_

#### 7) Check-Out with Patient Registration to complete visit and/or schedule a follow-up

Time: \_\_\_\_\_ Patient Registration Signature: \_\_\_\_\_

### **PLEASE STOP AT PATIENT REGISTRATION TO CHECK-OUT AFTER YOUR VISIT.**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0036-33. The time required to complete this information collection is estimated to average five minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.