**PATIENT STORY**

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| **Name (if consented):** |
| **Date of actual event**: |
| **Date of documentation**: |
| **Situation? (Brief description of the case)** |
|  |
| **Response? (What was needed from the clinician)** |
|  |
| **Assessment? (What did they do)** |
|  |
| **Where? (Was the review)** |
|  |
| **When? (Sunday, weekday, evening etc)** |
|  |
| **Impression from Patient** |
|  |
| **Issues** |
|  |
| **Actions** |
|  |
| **Difference made and what made the difference / What could have been improved?** |
|  |
| **Please identify which category this fits in:** Doctor / Band 7 / Band 6 / Oncologist / CNS |
|  |
| **Psychological support? yes/no** |
| **Out of hours review yes/no** |
| **Clinical skills used yes/no** |
| **Prescribing used yes/no** |