Records starter pack

Six worksheets and one worked example for keeping medical paperwork straight.

These blank worksheets organize information and tasks. They do not supply medical instructions or legal authority to access records. Keep passwords and sign-in codes somewhere else. Copy the fields you need into a private document, a spreadsheet, or a paper binder. The last page is a fictional completed example.

What's inside

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Medical summary for a visit

One page that says what matters, where it came from, and what is still unanswered.

Person whose records these are

Prepared by and relationship

Prepared on

Last checked against source records

Visit purpose

Receiving clinic and appointment details

What the team should know

Relevant condition, procedure, or event	Date or approximate date	Source document and page	Question or uncertainty

Current medication-list location and date

Allergies as documented, or details to verify

Relevant care-team contacts

Questions to ask

Priority question	Related record	Answer or next step
1.		
2.		
3.		

Keep the original reports with the summary. Leave clinical discrepancies for the care team to clarify.

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Records inventory and missing-item log

What you have asked for, what has arrived, and who does the next thing.

Collection owner

Paper location

Digital location

Backup location

Last successful backup retrieval check

People authorized to use this collection

Provider or source	Portal or records contact	Requested item and dates	Requested on	Status	Received format and location	Next action and owner

Useful status labels: not checked; requested; partly received; received; readable; sent to receiving clinic; receipt confirmed; usability confirmed; unavailable with reason.

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Portable medical binder index

One row per record, so anyone helping can find a document without opening every file.

Person whose records these are

Index prepared by

Index updated on

Where information-sharing preferences are recorded

Filename pattern: YYYY-MM-DD_Source_Document-type.extension. Use date-unknown when you need to. Use a range or a collection label for a multi-date export.

Record ID	Document or examination date	Source	Document type	Paper location	Digital filename and folder	Administrative notes
R001						
R002						
R003						
R004						
R005						
R006						
R007						
R008						
R009						
R010						
R011						
R012						

For each new record, check the person, the document date, page completeness, readability, where the original file lives, the index entry, and any related missing-record request. Mark clinical questions separately.

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Second-opinion packet and receipt log

Having a document, sending it, and confirming the clinic can read it are three separate events. This page tracks all three.

Patient details required by receiving clinic

Receiving clinic and department

Appointment or review type

Appointment date, time, and time zone, if assigned

Clinic contact

Person coordinating packet

Date clinic requirements were confirmed

Who supplied requirements

Location of written instructions

Referral, coverage, cost, and representative-access questions to confirm

What the receiving clinic asked for

Requested item	Examination or document date	Source organization and department	Required format or material	Confirmed destination
Written report				
Original images, if requested				
Pathology material, if requested				
Other requested record				

Sent and confirmed

Item	Requested on	Reference number	Sent on	Receipt confirmed by and date	Usability confirmed or pending	Next action and owner

Check that patient details, dates, and examinations match; that files open; that pages look complete; that originals stay intact; and that personal summaries are labeled separately. Follow the receiving service instructions for images and pathology material. A written report does not replace the other materials it asks for.

Still missing

Next contact

Next follow-up date agreed with office

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Caregiver handoff

What changed, what is open, and what the next person needs to know before you step away.

Person receiving care

Period covered

Prepared by

Prepared on, including time and time zone

Taking over

Acknowledged by

Acknowledged on

Current care-instructions location and date

Current medication-list location and date

Daily-log location

Information-sharing preferences or access arrangements to check

Care-team contact instructions, as supplied

Changes since the last handoff

Change since previous handoff	Date and source	Document location	Uncertainty or next action

Caregiver handoff (continued)

Open tasks

Open task	Next action	Agreed owner	Contact or document location	Date to act or check	Status

Appointments

Appointment	Date, time, time zone	Location or joining details	Attendance or transport owner	Confirmation source

Confirm together that the new helper can find the instructions, open the documents, name the agreed tasks, and see what is still unresolved.

Next handoff arrangement

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Appointment notes

Questions before, what was said during, and who does what after.

Person attending and role

Date, time, care team, location

Patient preferences about caregiver participation

Before

Priority question	Related record and page
1.	
2.	
3.	

During

What the team said	Source or speaker	What needs clarification

After

Next action	Agreed owner	Timing and source	Completion evidence

Ask permission before recording, and follow the clinic rules. Save the visit summary. If your notes and the written instructions disagree, ask the care team to clarify. Share the agreed update with the helpers who are authorized to see it.

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Fictional example: a records handoff

Every person and organization on this page is invented. It shows what finished paperwork status looks like. It is not medical advice.

Person: Alex Example
Visit date: To be confirmed
Receiving team: Riverbend Clinic, fictional
Coordinator: Morgan Example

Record or task	State	Next action and owner
Latest visit summary	Received; all pages readable	Morgan saves the original PDF in the visit folder
Current medication list	Copy located; needs confirmation	Alex asks the care team to confirm the current list
Imaging report	Report received; original-image requirement unknown	Morgan asks the receiving clinic whether images are needed
Records packet	Transfer method unconfirmed; not sent	Morgan contacts the records team before sending

Handoff message

> The visit summary and imaging report are in the shared visit folder. The medication list still needs checking. I have not sent the packet, because the receiving clinic has not confirmed its transfer method. Morgan will contact the records team and update the index once receipt is confirmed.

Folder layout

```
Visit-folder/
00-packet-index/
01-current-summary/
02-medication-list/
03-reports/
04-questions-and-notes/
```

The unfinished task stays visible to the next helper. Having a document, checking it, sending it, and confirming the clinic can read it are separate events.