San Francisco General Hospital
Point of Care Testing
Unit Log

Fecal Occult Blood

Nursing Unit _____

(**Directions:** Log every test performed & keep on file for 3 years.
Report Total Test Volume each Month to POCT Services.)

01.	**Date:**	**05.**	**Date:**
MRN: _____ **(or place patient ID sticker here)** **Provider:_____** **(Print Name)**		**MRN: _____** **(or place patient ID sticker here)** **Provider:_____** **(Print Name)**	
02.	**Date:**	**06.**	**Date:**
MRN: _____ **(or place patient ID sticker here)** **Provider:_____** **(Print Name)**		**MRN: _____** **(or place patient ID sticker here)** **Provider:_____** **(Print Name)**	
03.	**Date:**	**07.**	**Date:**
MRN: _____ **(or place patient ID sticker here)** **Provider:_____** **(Print Name)**		**MRN: _____** **(or place patient ID sticker here)** **Provider:_____** **(Print Name)**	
04.	**Date:**	**08.**	**Date:**
MRN: _____ **(or place patient ID sticker here)** **Provider:_____** **(Print Name)**		**MRN: _____** **(or place patient ID sticker here)** **Provider:_____** **(Print Name)**	