MR # DOB

NAME

DATE

* 1 0 1 8 *

BASSETT HEALTHCARE NETWORK
Cooperstown, NY 13326-1394

POINT OF CARE FERN PROVIDER PERFORMED (POC 50)

H-1018 1/13;10/14;12/17 (d:\forms\hosp\.ofm)

BASSETT HEALTHCARE NETWORK

Location/Health Center _____

Address: _____

_____

Test Date: _____ Test Time: _____ Tech Initials: _____

Fern Result:

☐ Ferning present

☐ Ferning absent

Provider Order
Signature: _____ Provider #: _____ Date: _____ Time: _____

Provider Review
Signature: _____ Provider #: _____ Date: _____ Time: _____

LABORATORY Point of Care

White – Chart; **Yellow** – Coder