

**SOUTH AUSTIN MEDICAL CENTER**  
CASE LOG *for*  
ALLIED/DEPENDENT HEALTH PROFESSIONALS

NAME OF AHP: \_\_\_\_\_  
(Print Full Name)

|    | Medical Record # | Date (s) of Service | TYPE OF SERVICE* | SPONSORING PHYSICIAN<br><i>(for each case)</i> |
|----|------------------|---------------------|------------------|--|
|    |                  |                     |                  |  |
| 1  |                  |                     |                  |  |
|    |                  |                     |                  |  |
| 2  |                  |                     |                  |  |
|    |                  |                     |                  |  |
| 3  |                  |                     |                  |  |
|    |                  |                     |                  |  |
| 4  |                  |                     |                  |  |
|    |                  |                     |                  |  |
| 5  |                  |                     |                  |  |
|    |                  |                     |                  |  |
| 6  |                  |                     |                  |  |
|    |                  |                     |                  |  |
| 7  |                  |                     |                  |  |
|    |                  |                     |                  |  |
| 8  |                  |                     |                  |  |
|    |                  |                     |                  |  |
| 9  |                  |                     |                  |  |
|    |                  |                     |                  |  |
| 10 |                  |                     |                  |  |
|    |                  |                     |                  |  |

**\*Indicate type of service:**

**A** - Anesthesia  
**P** - Progress Notes  
**R** - Rounds

**S** - Scrub  
**O** -Orders  
**X** - Other: *explain any other service provided*