Home Health Agency Corp.

CASE CONFERENCE/60 DAY SUMMARY

PATIENT NAME: ______________________ MR: ________

☐ 60 DAY SUMMARY
☐ CASE CONFERENCE
☐ TRANSFER
☐ DISCHARGE

START OF CARE: ______________________

PHYSICIAN: ______________________

PERIOD REVIEWED FROM: ____/____/____ TO: ____/____/____

STATUS ON ADMISSION OR RECERTIFICATION PERIOD:

☐ ALERT ☐ ORIENTED ☐ DISORIENTED ☐ FORGETFUL ☐ OTHER: ______________________

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SERVICES PROVIDED: ☐ SN ☐ AIDE ☐ PT ☐ OT ☐ MSW ☐ ST ☐ NUTR ☐ RESPIRATORY

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☐ PROGRESS
☐ STABLE
☐ DETERIORATION

☐ HOSPITALIZED FROM: ________ TO: ________
☐ VERBAL ORDERS OBTAINED: ______________________

____

____

BSL: ☐ STABLE ☐ UNSTABLE: ________

BP: ☐ STABLE ☐ UNSTABLE: ________

☐ PROBLEMS: ______________________

☐ RESPONSE: ______________________

☐ OTHER: ______________________

____

PLAN FOR FOLLOW UP/RECOMMENDATIONS:

☐ CONTINUE WITH SAME PLAN OF CARE ☐ OTHER:

____

____

CASE CONFERENCE PARTICIPANTS:

____

____

ASSISTING ANGELS
HOME CARE, INC.

CLINICAL RECORDS: **SUMMARY REPORTS** - COMMUNICATION NOTE

☐ 60 day Summary Report ☐ Communication Note

Patient's name: ______________________________

Date of this report: Medical Record: ______________

Name of reporting staff: ______________________________

Diagnosis:

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Date started services to patient: ______________________________

Brief summary/Communication:

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(to include major services rendered, patient's response to treatment (progress or deterioration), any significant findings/communication, and recommendations to the physician)

Physician Contacted (summary sent/faxed) date: ______________

Signed: ______________________________

PATIENT'S CASE CONFERENCE/60 DAYS SUMMARY

PATIENT NAME ________________________________ **PATIENT NUMBER** ____________
START OF CARE__________________ PHYSICIAN ____________________________________

REASON: []DISCHARGE []TRANSFER **[]CASE CONFERENCE [] 60 DAY SUMMARY**
NOTIFIED: PHYSICIAN: [] YES [] NO

STATUS ON ADMISSION OR RECERTIFICATION PERIOD:

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____
____

SERVICES PROVIDED SN PT ST OT MSW AIDE NUTR RESPIRATORY (Briefly description)

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PROGRESS/DETERIORATION / PROBLEMS/RESPONSE/GOALS:

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	MET		**MET**
PT'S BILL OF RIGHTS	[]YES []NO [] N/A	**INDEPENDENT**	[]YES []NO []PARTIAL
WOUND/DECUBITUS/SURGERY HEALED	[]YES []NO [] N/A	AMB.	[]YES []NO []PARTIAL
SYMPTOM CONTROL	[]YES []NO [] PARTIAL	TRANSFER	[]YES []NO []PARTIAL
VITAL SIGNS STABLES	[]YES []NO [] PARTIAL	ADL's	[]YES []NO []PARTIAL
BLOOD SUGAR RANGE __________	[]YES []NO [] N/A	DME USE	[]YES []NO []PARTIAL
UNDERSTANDS / COMPLIES	[]YES []NO [] PARTIAL	**STABLE**	[]YES []NO []PARTIAL
MEDICATIONS	[]YES []NO [] PARTIAL	CARDIAC	[]YES []NO []PARTIAL
DIET REGIMEN	[]YES []NO [] PARTIAL	RESP	[]YES []NO []PARTIAL
TREATMENT PROGRAM	[]YES []NO [] PARTIAL	NUTRITION	[]YES []NO []PARTIAL
SIGNS AND SYMPTOMS	[]Y ES []NO [] PARTIAL	G.I.	[]YES []NO []PARTIAL
SAFETY MEASURES	[]YES []NO []PARTIAL	G.U.	[]YES []NO []PARTIAL
GOALS ACHIEVED	[]YES []NO []PARTIAL	MENTAL	[]YES []NO []PARTIAL

CASE CONFERENCE PARTICIPANTS:

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____
____

Case Conference at: BY PHONE [ ] PATIENT'S HOME [ ] OFFICE [ ]
PLANS FOR FOLLOW-UP/RECOMMENDATIONS:

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STAFF SIGNATURE ______________________________ DATE ______________