Inpatient Encounter Form

VisionQwest Healthcare
Home Health Encounter Form
Week Ending Date: ___________________________

		Patient Name	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10
		Patient Number										
		Patient Room Number	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Patient Diagnosis	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Service Category	TIME IN	TIME OUT	DATE PERFORMED	DATE PERFORMED	DATE PERFORMED	DATE PERFORMED	DATE PERFORMED	DATE PERFORMED	DATE PERFORMED	DATE PERFORMED	DATE PERFORMED	DATE PERFORMED
INITIAL ASSESSMENT / EVALUATION												
PROGRESS / FOLLOW UP												
RECERTIFICATION RESUMPTION OF CARE												
PRN / CHANGE IN CONDITION												
SUPERVISOR												

EMPLOYEE SIGNATURE DATE:

HOME HEALTH AGENCY ADMIN DATE