



**PACIFIC HOME HEALTH CARE**

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www.PacificHHC.com

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# MISSED VISIT(S) NOTES

Patient Name (Last, First, M.I.):	ID#:
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Date of Missed Visit:

*This is to notify you that based on your ordered visit frequency, a home visit(s) was/were not made on the date(s) noted by the discipline and for the following reason(s).*

**TYPE OF VISIT:**

- |   |  |
|---|--|
| <input type="checkbox"/> Skilled Nursing      | <input type="checkbox"/> Medical Social Worker |
| <input type="checkbox"/> Physical Therapy     | <input type="checkbox"/> Home Health Aide      |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Speech Therapy       |  |

**REASON(S) FOR CANCELLATION:**

- |   |  |
|---|--|
| <input type="checkbox"/> Not home / Not found     | <input type="checkbox"/> Emergency / Disaster                                      |
| <input type="checkbox"/> M.D. Appointment         | <input type="checkbox"/> Patient refused alternative staff and/or visit date, time |
| <input type="checkbox"/> Patient / Family request | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Inclement weather        |  |
| <input type="checkbox"/> M.D. Notified            | Date faxed to M.D.: _____  |
| <input type="checkbox"/> Visit Rescheduled        | Date: _____  |

Signature: \_\_\_\_\_ Discipline: \_\_\_\_\_ Date: \_\_\_\_\_

Follow-Up Action / Comment: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_