matrix
HOME HEALTH CARE

Single Visit Note

Date: _____

PATIENT DATA

PATIENT NAME: | PT ID #: | HT _____ | WT _____ | DOB:

Location, Address of Visit: | Phone:

Physician Name: | Phone:

MEDICAL DATA

Primary Diagnosis: (Supports this Visit) | ICD-9: | Date of Onset:

Secondary Diagnosis: | ICD-9: | Date of Onset:

Allergies:

Physician's Orders:

ASSESSMENT

Functional Limitations (Check all that apply):

❑ Amputation	❑ Dressing (Grooming)	❑ Language
❑ Bowel/Bladder Incontinence	❑ Meal Preparation	❑ Ability to Learn
❑ Paralysis	❑ Housekeeping	❑ Nutritional Needs
❑ Blindness	❑ Contracture	❑ No Limitations
❑ Dyspnea	❑ Hearing	❑ Other _____
❑ Ambulation	❑ Bathing	
❑ Speech	❑ Telephone Use	

Vital Signs: T: ❑ O ❑ A ❑ R ❑ E Pulse: ❑ Radial ❑ Apical Respiration: Blood Pressure:

History/Assessment Findings Relevant to Services Provided:

GOAL/ACTION/ OUTCOME

Goal of Visit:

Interventions/Actions:

Outcome: Patient Tolerated Procedure: ❑ Yes ❑ No Goals met: ❑ Yes ❑ No

DISCHARGE

Patient/Caregiver Instructions:

❑ Patient's Rights	Patient has Advanced Directives: ❑ Yes ❑ No
❑ Disease ❑ Procedure	Patient Instructed on Advanced Directive: ❑ Yes ❑ No
❑ Medication Information	Patient/Caregiver Independent in Care: ❑ Yes ❑ No
❑ Equipment Information	Satisfaction Return Demo: ❑ Yes ❑ No
❑ Other	Patient/Caregiver Verbalized Understanding: ❑ Yes ❑ No

Referred to:

I hereby authorize Matrix Home Care to render appropriate home care services. I, _____
certify that the employee arrived at _____am / pm, left at _____ am / pm, and provided (Patient/Caregiver Signature)
satisfactory care.

Employee Signature/Title: _____ Date: _____

Physician's Name (printed) | Patient's Name (Printed)

Physician's Signature Date | Patient's Signature Date

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