

Ken Care Services, Inc.

WEEKLY VISIT/TIME RECORD

Year: _____

Employee ID# _____

Employee Name/Title _____ Emp. Signature: _____

Patient Name _____ Med. Record # _____

Patient Address _____ Apt # _____

The undersigned hereby certifies that the information contained in this weekly visit/time record is real time and does not conflict with any other entity, and that all clinical documents are true, correct and specific to the patient's condition and adheres to the Agency's patient care philosophy. The undersigned agrees to allow an Agency designee to audit the notes for verification of compliance with the Agency policies and Federal Regulations.

PLEASE SIGN FOR ONLY ONE VISIT AT A TIME
POR FAVOR SOLO FIRME POR UNA VISITA A LA VEZ

Day <i>Dia</i>	Date <i>Fecha</i>	Visit Code	N/C Code	Time In <i>Entrada</i>	Time Out <i>Salida</i>	Units <i>Unidades</i>	Patient signature <i>Firma del paciente</i>

TOTAL VISITS: _____

VISIT CODES
 P – Patient Visit (SN, PT, SLP, OT, MSS, AIDE, RD)
 X – Psych RN Visit
 HT – High Tech Infusion Therapy Visit
 S/U – Sign Up Visit
 WC – High Tech Wound Care
 SV – Supervisory Visit
 Hmk – Homemaker

N/C CODES (NO/CHARGE)
 1 – Supervisory Visit
 2 – RN S/U Therapy Only
 3 – Not Home Or Refused
 4 – Charity Visit
 5 – Travel Only
 6 – Supply Drop
 7 – Not Qualified