ST. JAMES HOME HEALTH, INC.

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DISCIPLINE VISIT LOG

Clinician's Name:	**Date Prepared:**
Patient's Name:	**Medical Record Number:**

By my signature herein affixed below, attest that the above-named Clinician rendered services on the specific date and that I was satisfied with the services provided.

Date of Visit	Time In	Time Out	Patient's/Representative Signature	* Type of Visit

Submitted by:

_____ _____

Signature of Clinician Date

LEGEND: *SOC Start of Care, *ROC Resumption of Care, *R Revisit, *EVAL Evaluation, *F/A Functional Assessment, *D/C Discharge