

PRIMA HOME HEALTH, INC.

Procedure Documentation

MO/YR:	Start/Stop Date		Facility Name:																														
Procedure		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start																																
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	Stop																																
Diagnosis:		DIET (Special Instructions, e.g. Texture, Bite Size, Position, etc.)															Comments																
Allergies:					Physician Name															A. Put initials in appropriate box when medication is given. B. Circle initials when not given. C. State reason for refusal / omission on back of form. D. PRN Medications: Reason given and results must be noted on back of form. E. Legend: S = School; H = Home visit; W = Work; P = Program.													
					Phone Number																												
NAME:									Record #											Date of Birth:							Sex:						

VITAL SIGNS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
TEMPERATURE																															
PULSE																															
RESPIRATION																															
WEIGHT																															

PRN AND MEDICATIONS NOT ADMINSTERED								Initials		Staff Signature	
Date	Hour	Initials	Medication	Reason	Result						
						1					
						2					
						3					
						4					
						5					
						6					
						7					
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Name							MO/ YR				