PAYER SOURCE

☐ MEDICARE
☐ MEDICAID
☐ OTHER

LESLY HOME HEALTH CARE, INC.

WEEKLY VISIT LOG

PATIENT NAME ______________________ STAFF NAME (PRINT) ______________________

ADDRESS ______________________ STAFF SIGNATURE ______________________ # __________

MR# ______________________ Type of Service RN LPN PT ST OT MSW HHA

DATE		PATIENT SIGNATURE		VISIT TYPE EV. S/U. R/C.	RV HV	A.M. TIME IN / TIME OUT	P.M. TIME IN / TIME OUT
		A.M. VISIT	P.M.				
S							
M							
T							
W							
Th							
F							
St							

N/C (NO CHARGE CODE)

1. **PATIENT NOT HOME**
2. **PATIENT REFUSED VISIT**
3. **M.D. APPOINTMENT**
4. **SUPPLY DROP / MILEAGE ONLY**