FIRST CHOICE HOME HEALTH, INC.
BI-WEEKLY VISIT RECORD

PATIENT NAME: _____ MR#: _____

EMPLOYEE NAME: _____

Discipline: RN ____ Psych RN ____ LPN ____ PT ____ ST ____ OT ____ MSW ____ HHA ____

PLEASE SIGN FOR ONLY ONE VISIT AT A TIME

DATE	PATIENT SIGNATURE

TOTAL VISITS: _____

PATIENT/REPRESENTATIVE SIGNATURE ON THIS FORM CONSTITUTES CERTIFICATION THAT VISITS ARE CORRECT AND THAT WORK WAS PERFORMED IN A SATISFACTORY MANNER.