INTEGRITY HOME HEALTH CARE SERVICES - REVISITS

PATIENT NAME: ______________________________ DOB: ______________ MRN: ______________

DATE & TIME	NOTES
S M T W T F S	TEMP: O / AX / R / TYMP / TEMP PULSE: AP / RP REG / IRREG RESP: CLR, WHZ, RHNC, OR? BP: L / R – LYING / SIT / STAND LAST BM: O2 SAT: BLD SUGAR LEVEL & TIME: EDEMA: VOIDING OK?: PAIN LEVEL: WHERE? NEW MEDS?: LINE, LUMEN & LOCATION: LAST DRESING CHANGE: DRESSING TODAY: INDICATE IF: ALCOHOL-IODINE / CHLOROPREP LABS? IV DRUG LIST & REMAINING COUNT: WOUND MEASURM'T DUE?:
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