LICENSED NURSE SERVICES
CLIENT CARE LOG

Client Name: _____ **Care Provider Name:** _____

Role: ☐ RN ☐ LPN **Week Ending Date:** _____
☐ Licensed Nurse ADL/ Homemaker Services Only

Pursuant to Regulations by the Agency for Health Care Administration, it is mandatory that Care Provider document any changes in care services.

DATE:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
HOURLY/ VISIT START TIME:							
HOURLY/VISIT END TIME:							
TOTAL HOURS:							
DAILY CLIENT REVIEW & APPROVAL (CLIENT INITIALS)							
SKILLED LICENSED NURSING SERVICES: *PHYSICIAN ORDERS REQUIRED*							
TREATMENT AS ORDERED PER POT, SEE CLINICAL NOTES							
MEDICATION ADMINISTRATION AS ORDERED PER POT, SEE NOTES							
PHYSICIAN NOTIFICATION, SEE NOTES							
MISSED VISIT – NOT BILLABLE, SEE NOTES							
INITIAL ASSESSMENT & MEDICAL PLAN OF TREATMENT							
RE-ASSESSMENT & AMENDED MEDICAL PLAN OF TREATMENT							
60-DAY REASSESSMENT & MEDICAL PLAN OF TREATMENT							
REASSESSMENT WITH NO AMENDED ORDERS, SEE NOTES							
MEDICATION SCHEDULE COMPLETE & REVIEWED							
LICENSED NURSING SERVICES: *PER CLIENT REQUEST, PHYSICIAN ORDERS NOT REQUIRED*							
ASSESSMENT							
MEDICATION SCHEDULE REVIEW							
CUSTODIAL "ADL" PLAN OF CARE							
CLIENT/FAMILY/ CAREGIVER EDUCATION/ TRAINING, SEE NOTES							
OTHER: Please specify -							
As per the direction of Client, the Licensed Nurse also performed the following services: **COMPANIONSHIP/ HOMEMAKER/**							
IADL SUPERVISION / STANDBY ASSIST							
ACCOMPANY TO APPOINTMENTS							
PREPARE MEALS							
GROCERY SHOPPING							
CHANGE BED LINEN							
LAUNDRY							
LIGHT HOUSEKEEPING							
COSMETIC ASSISTANCE							
PERSONAL CARE /ADL ASSISTANCE							
BATHING/SHOWER							
DRESSING							
AMBULATION							
TRANSFERRING							
RE-POSITIONING							
RANGE OF MOTION ASSISTANCE							
FEEDING							
GROOMING, SHAVING, HAIR CARE							
APPLY LOTION							
ORAL HYGIENE							
TOILETING							
INCONTINENCE CARE							
OTHER ADL ASSIST, SEE CLINICAL NOTES							

By signing below, I (Client) contracted with Care Provider for whom I consent and certify that all services noted above within the approved dates and times were performed. I understand that if services were not performed as requested, I would not sign this care log. Care logs submitted without the checking of Activities of Daily Living actually performed, and required by the insurance company, may result in the patient/client being billed directly.

Signed by Client: _____

By signing below, I (Care Provider) certify that this Care Log represents the actual care services requested by Client and provided by me as the Independent Care Provider for the dates listed above.

Signed by Care Provider: _____

Client Care Logs with Clinical Notes may be submitted to Financial Services via:
Fax: 888-789-4701 or Email: nurseworklogs@americaninhomecare.com

CLINICAL NOTES

Client Name:_____ Nurse: _____

DATE	TIME	DESCRIPTION

Nurses Signature_____ Title _____ Date ____/_____/____

PRIOR TO SUBMITTING THE CLIENT CARE LOG AND CLINICAL NOTES TO FINANCIAL SERVICES, SUBMIT ALL APPLICABLE CLINICAL DOCUMENTS TO CLINICAL SERVICES FOR CLIENT'S FILE:

MAIL: 2605 W Atlantic Ave., Suite B101, Delray Beach, FL 33445; **FAX:** 561-819-6617; **OR EMAIL:** clinicaldept@americaninhomecare.com

Please check all applicable clinical documents requested at the time services were delivered.

- ❑ Initial Medical Plan of Treatment
- ❑ 60-Day Medical Plan of Treatment
- ❑ Medication Schedule
- ❑ Amended Medical Plan of Treatment, see notes for Physician correspondence.
- ❑ Custodial "ADL" Plan of Care
- ❑ Other Clinical Document, Specify: _____
- ❑ Nurse Evaluation (Assessment)
- ❑ N/A: No additional Documentation Required

Financial services will not process billing and disbursement without proof of the required clinical documents in the Client's file.

Per 59A-18.012, F.A.C., (4) Clinical and service notes, signed and dated by the nurse providing the service which shall include: (a) Any assessments by a registered nurse; (b) Progress notes with changes in the person ' s condition; (c) Services provided; (d) Observations; and(e) Instructions to the patient and caregiver; (5) Reports to physicians; (6) Termination summary. Per 59A-18.007, (2), F.A.C., the licensed nurse is responsible "for maintaining the medical plan of treatment with clinical notes and filing the initial medical plan of treatment, any amendments to the plan, any additional order or change in orders, and a copy of the clinical notes at the office of the nurse registry."

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