SHEPHERD HOME HEALTH CARE, INC.
5455 Wilshire Blvd. #705
Los Angeles, CA 90036
Tel. (323) 932-8851 Fax. (323)932-8983

Patients Name: _____ **SOC: _____**

MD: _____ **Calendar Week: _____**

FIELD NOTES

ALL staff is to sign and log information at the time of each visit.

DATE	TIME	TEMP.	PULSE	RESP.	BP	FBS	RBS	COMMENTS (PAIN ASSESMENT/ INSULIN DOSE)	SIGNATURE/ TITLE

AGENCY policy regarding <u>REPORTING PATIENT CHANGE IN CONDITION</u>* requires that the following conditions, unless other specific parameters have hen established by the patient's physician, must be reported to the attending physician by a health professional once it is identified ……..

1. Temperature: > 100 degrees F
2. Pulse Rate: <60 or >120/min
3. Respiration Rate: < 12 or >30/min
4. Blood Pressure: SBP > 170 or < 90 mmHg, DBP > 100 or <50 mmHg or
Physician specified parameter of: _____
5. Blood Sugar: FBS < 70 or > 300 mg/dl, RBS <70 or > 400 mg/ dl or
Physician specified parameter of: _____
6. OTHER: _____