CENTER FOR PHYSICAL THERAPY SERVICES, INC.

SIGN IN SHEET

PATIENT NAME: _____ MR#: _____

DATE (MM/DD/YYYY)	TIME (MILITARY TIME)	BLOOD PRESSURE*	PULSE★	RESP.*	TEMP.*	PAIN*	WEIGHT/ OXYGEN SAT. ★★	THERAPY NOTES [FALLS, HOSPITALIZATIONS, NEXT MD APPT, PAIN >6/10, ANY SCIC]	CENTER4PT HOME HEALTH CARE STAFF (NAME, TITLE)
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★ REFER TO THE VITAL SIGN PARAMETERS SHEET

★★ WEIGHT, OXYGEN SATURATION, BLOOD SUGAR MONITORING ARE DONE ONLY WHEN ORDERED BY THE PHYSICIAN THROUGH AN MD ORDER (E.G. FORM 485)