

PATIENT NAME: \_\_\_\_\_

MR#: \_\_\_\_\_

| DATE<br>(MM/DD/YYYY) | TIME<br>(MILITARY<br>TIME) | BLOOD<br>PRESSURE* | PULSE* | RESP.* | TEMP.* | PAIN* | WEIGHT/<br>OXYGEN<br>SAT. ** | THERAPY NOTES<br>[FALLS, HOSPITALIZATIONS, NEXT MD APPT, PAIN >6/10, ANY SCIC] | CENTER4PT HOME HEALTH CARE STAFF<br>(NAME, TITLE) |
|----------------------|----------------------------|--------------------|--------|--------|--------|-------|------------------------------|--|---|
|                      |                            |                    |        |        |        |       |                              |  | PRINT   |
|                      |                            |                    |        |        |        |       |                              |  | SIGN/TITLE  |
|                      |                            |                    |        |        |        |       |                              |  | PRINT   |
|                      |                            |                    |        |        |        |       |                              |  | SIGN/TITLE  |
|                      |                            |                    |        |        |        |       |                              |  | PRINT   |
|                      |                            |                    |        |        |        |       |                              |  | SIGN/TITLE  |
|                      |                            |                    |        |        |        |       |                              |  | PRINT   |
|                      |                            |                    |        |        |        |       |                              |  | SIGN/TITLE  |
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|                      |                            |                    |        |        |        |       |                              |  | SIGN/TITLE  |
|                      |                            |                    |        |        |        |       |                              |  | PRINT   |
|                      |                            |                    |        |        |        |       |                              |  | SIGN/TITLE  |
|                      |                            |                    |        |        |        |       |                              |  | PRINT   |
|                      |                            |                    |        |        |        |       |                              |  | SIGN/TITLE  |

\* 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)