Patient Signature Log

Patient Name: _____

Agency: _____

MD Name/Number: _____

Certification Period: _____ TO _____

Date:	Visit Type:	Time In:	Time Out:	Vitals: BP/Pulse/Resp/O2	Patient Signature:

Vitals Parameters *(Medicare Certified HHA)*		**Vitals Parameters** *(CHAP Certified HHA)*	
Systolic:	>180 or <90	Systolic:	>160 or <90
Diastolic:	>100 or <50	Diastolic:	>90 or <60
Respiration:	>30 or <14	Respiration:	>24 or <12
Pulse:	>105 or <55	Pulse:	>120 or <60
O2 Sat %:	<90%	O2 Sat %:	<92%
Pain:	6/10 or Higher	Pain:	5/10 of Higher

*I understand as a contract therapist it is my responsibility to follow respective agency's guidelines when vitals fall outside of normal limits.

Signature:_____

Discipline:_____

Invoice Period:_____

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