2497 State Road
Cuyahoga Falls, Oh 44223
330-929-5512

MISSED VISIT NOTIFICATION

Patient Name _______________________________________DOB_______________________

Missed Visit Date(s) ____

Service (circle): SNV PDN AIDE PT PTA OT OTA ST LISW

Missed visit(s) due to:

- ☐ Patient not home/not found____
- ☐ Refused visit/care due to ____
- ☐ Alternate staff offered and accepted
- ☐ Alternate staff offered and refused
- ☐ Visit rescheduled for (Date)____
- ☐ Other (be specific) ____

If this missed visit(s) resulted in being out of frequency the physician MUST be notified. If this is the case, complete the following:

Dr. _______________________________________ was notified on _________________
Physician name Date
by _____________________________that the above circled service(s) was out frequency.

Additional comments ____

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____ _______________________________

Staff Signature Date

____ _______________________________

Supervisor Signature Date