WellsBrooke
CERTIFIED HOME HEALTH CARE

☐RN / LPN ☐PT
☐OT ☐SLP
☐MSW ☐Hha

Start of Care (SOC) / Initial Visit Delay Note

Patient Name:_____ **MR#:** _____

Referral Date:_____

Reason for delayed SOC/initial visit (Please ✓ all that apply)**:**

☐ Patient is still in_____ hospital, will be discharged on_____ (date)
☐ Per patient/family request
☐ Patient has doctor appointment on _____(date)
☐ Patient is relocating to a different address.
☐ Other: _____

New anticipated SOC/initial visit date:_____

- Physician notified of delayed SOC **and** new anticipated SOC/initial visit date?
  ☐ Yes - Date/Time:_____ Verbal Order Attached: ☐ Yes ☐ No
  ☐ No - Reason:_____
- Patient/Caregiver notified of delayed SOC **and** new anticipated SOC/initial visit date (as applicable)?
  ☐ Yes - Date/Time:_____
  ☐ No - Reason:_____
  ☐ N/A
- WellsBrooke Certified Home Health Care notified of delay SOC **and** new SOC/initial visit date?
  ☐ Yes - Date/Time:_____
  ☐ No - Reason:_____
  ☐ N/A

Additional Comments:

_____

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Signature :_____ **Date:**_____

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White Copy-Office Yellow Copy-Patient