

# CARE PLAN OVERSIGHT LOG SHEET

Patient Name: \_\_\_\_\_ Agency Name: \_\_\_\_\_

Date (month/day/year)																			Total Time with Patient	
Development of Care																				
Revision to Care Plan																				
Review of Patient Reports																				
Lab Reviews																				
Diagnostic Test Reviews																				
Communication with Other Health Care Professionals																				
Integration of New Information into Treatment Plan																				
Adjustment of Medial Therapy																				
Other (Define)																				

Physician Signature: \_\_\_\_\_

Total Time:

Form must be signed by a Billing Provider