CARE PLAN OVERSIGHT LOG SHEET

Patient Name: _____ **Agency Name:** _____

																Total Time with Patient
Date (month/day/year)																
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