 **Therapy Daily Summary of Service Documentation Fax**

TO: PBC FROM: Agency Name: **Verve Rehab**

Advocate Home Health Services 224-347-2855

Fax # 630-368-6620 (only fax to these numbers) Agency/ therapist contact phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Pages Including Cover\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NORTH BRANCH**

Therapist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Discipline:  **ST**  Resource # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinician should fax all original paperwork within 24hrs of the visit to 630-368-6620 with this completed cover sheet. Please fill in the Summary of Service log completely and legibly using correct codes or visits cannot be credited to you and your patients.**

**The following visits were done on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date of visit) and all required paperwork for visits are included with this fax**.

Please use Code reference sheet for identification correct Code for visit

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Code for Visit** | **Patient Name** | **Patient Number** | **Time**  **IN** | **Time OUT** | **Eval Frequency and Duration/**  **Other Comments** |
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