Healing Hands
Home Health Care

Visit/Shift Variance Report

Patient/Client Name: _____

Complete one form for following:

- Each missed visit/shift
- Providing fewer hours than ordered for treatment

This form is being completed for:

☐Missed Visit ☐Missed Shift ☐Hours provided less than ordered

For week ending:_____

Date of Missed Visit/Shift or hours provided less than ordered: _____

Discipline:

☐ RN/ LPN/ LVN ☐Aide ☐PT ☐OT ☐ST ☐MSW ☐Homemaker/Companion

☐Other (please specify):_____

Reasons for missed visit/shift or providing fewer hours:

☐Patient/client had physician appointment
☐Unable to locate patient/client
☐Patient/client or family* declined service
☐Patient/client or family* declined alternate caregiver
☐Patient/client scheduled for diagnostic test/labs
☐Severe weather prevented delivery of service
☐Qualified staff not available
☐Other (specify)

**Includes other authorized individuals*

Patient/Client needs met by: (e.g. family, caregiver, etc..)_____

Mark all that apply:

Notification made to:	**Notification made by:**	**Date and time Notified**
☐Physician*_____	☐Phone ☐Mail ☐Fax ☐Email ☐Other_____	
☐Case Manager	☐Phone ☐Mail ☐Fax ☐Email ☐Other_____	
☐Family/Caregiver	☐Phone ☐Mail ☐Fax ☐Email ☐Other_____	
☐Other	☐Phone ☐Mail ☐Fax ☐Email ☐Other_____	

**Notification required to physician for all care/service with orders.*

Comments:_____

_____

Signature/Title:_____**Date**:_____