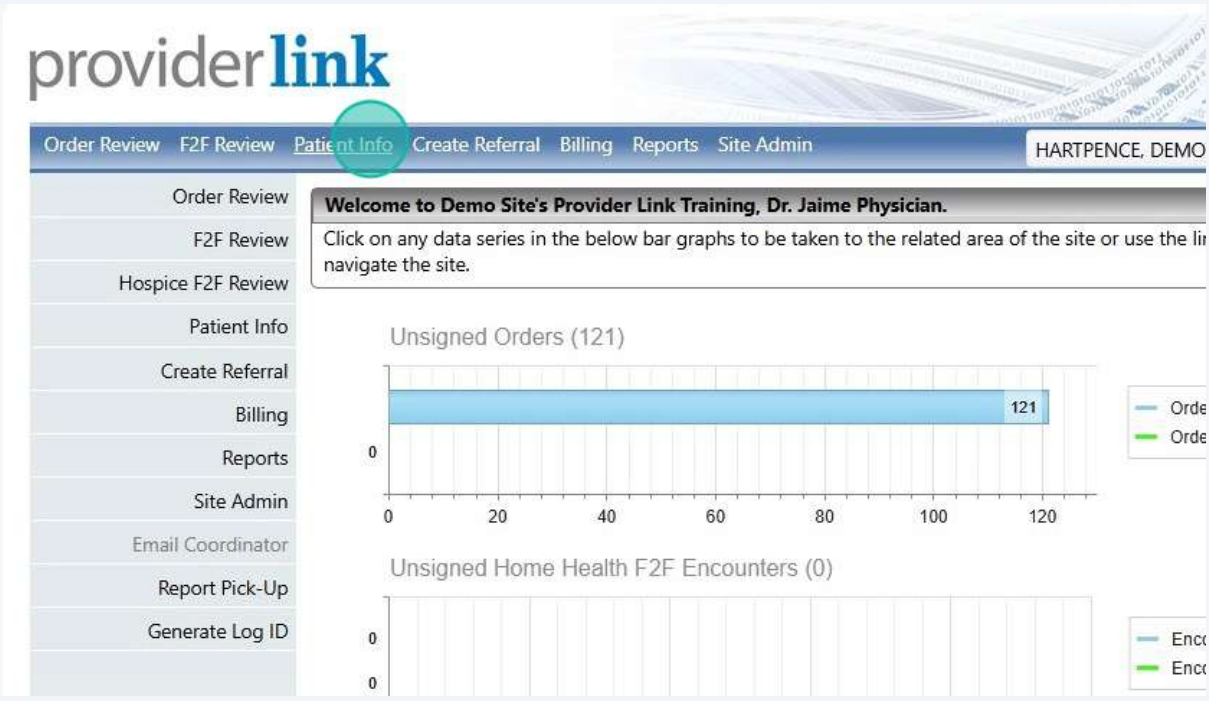
Provider Link: How to View Visit Notes

This guide is essential for healthcare providers looking to efficiently access and review visit notes within Provider Link. It outlines how to navigate the system to find patient information and visit details, ensuring continuity of care and effective communication among the care team. By understanding how to utilize this functionality, providers can enhance their clinical decision-making and documentation practices, ultimately improving patient outcomes.

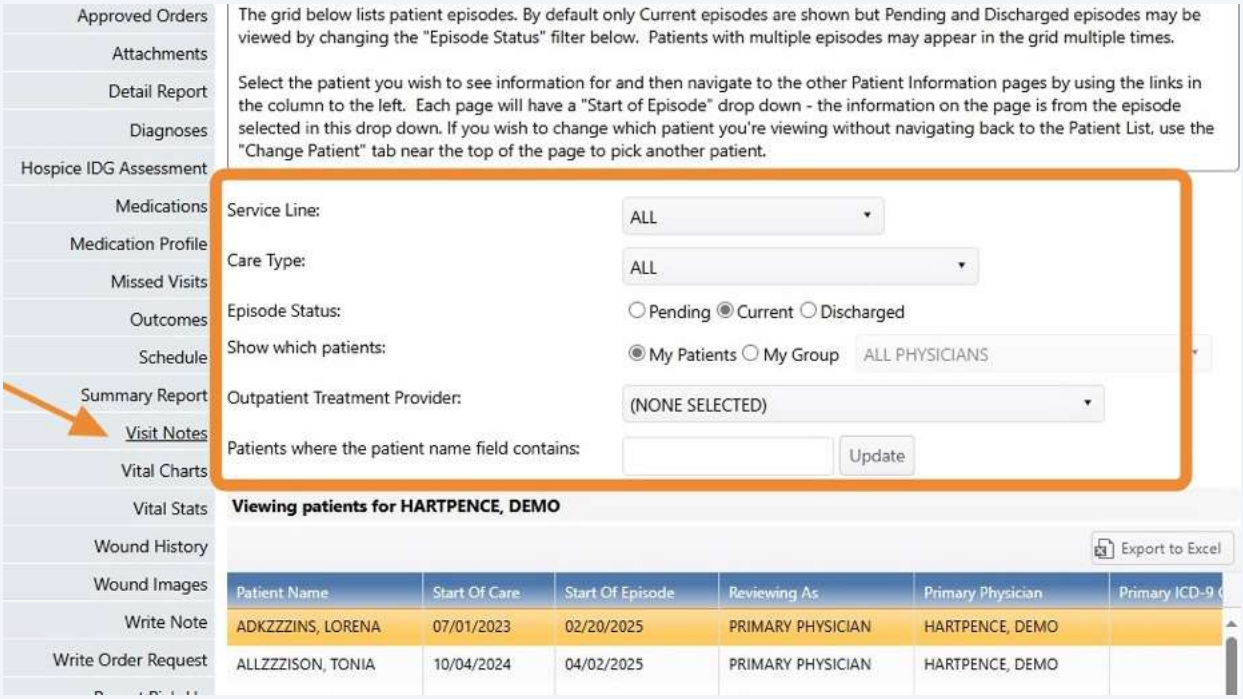
1 Once logged into Provider Link, navigate to the *Patient Info* tab. This tab provides access to the patient's demographics and episode information.



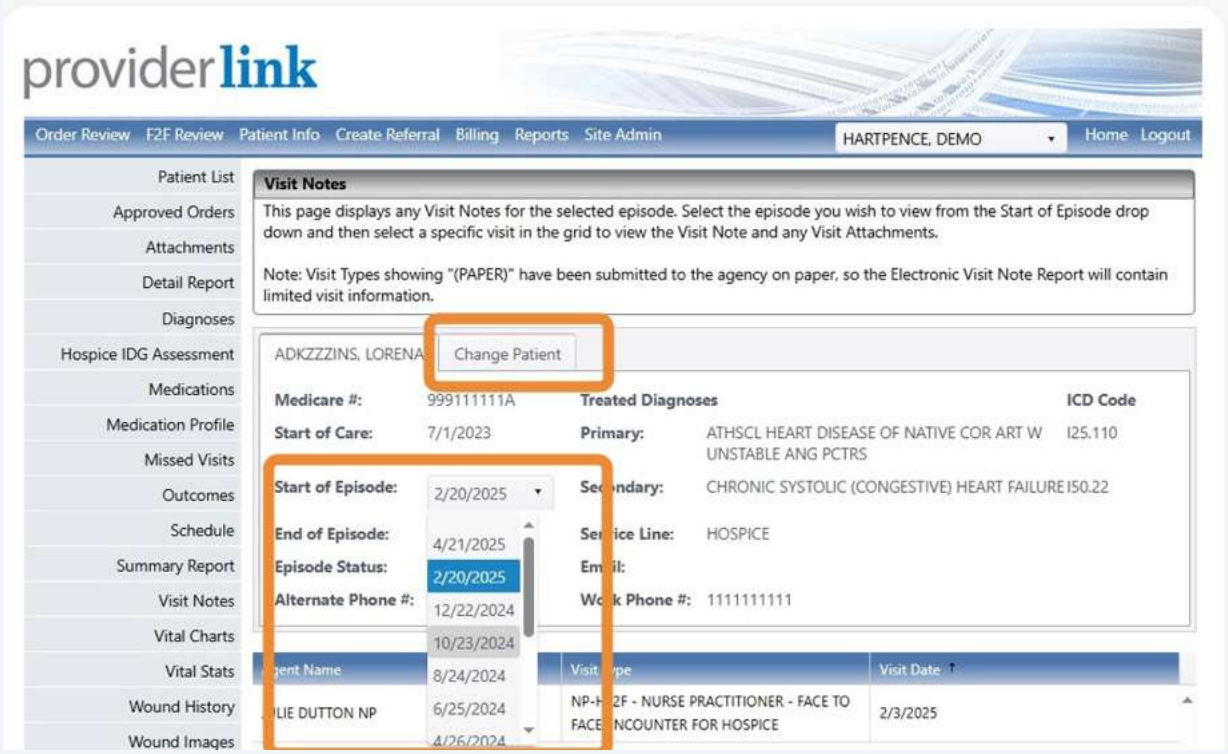
2 You can search for a patient using the Patient List or go directly to the Visit Notes section.

Note:

This functionality is determined by settings in the physician's profile in Homecare Homebase. If a provider does not see this option, the configuration may need to be updated based on the agency's preferences.



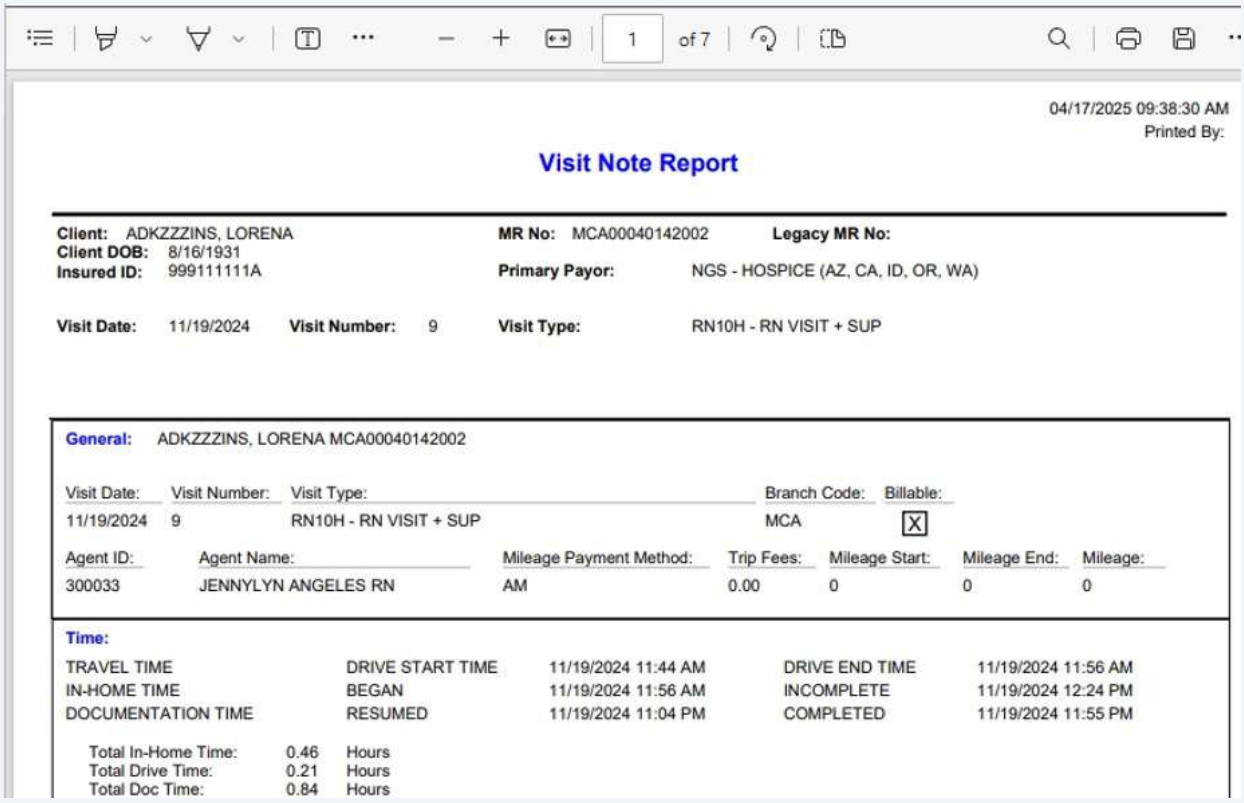
3 In the Visit Notes section, you can switch between episodes or select a different patient as needed.



4 Completed visit notes are listed below. Click on the note you wish to review.

5 The visit information will display many important details, including the time spent completing the visit.

Reminder: These reports can be saved or printed at your convenience.



04/17/2025 09:38:30 AM
Printed By:

Visit Note Report

Client: ADKZZZINS, LORENA
Client DOB: 8/16/1931
Insured ID: 999111111A
MR No: MCA00040142002 **Legacy MR No:**
Primary Payor: NGS - HOSPICE (AZ, CA, ID, OR, WA)

Visit Date: 11/19/2024 **Visit Number:** 9 **Visit Type:** RN10H - RN VISIT + SUP

General: ADKZZZINS, LORENA MCA00040142002

Visit Date:	Visit Number:	Visit Type:	Branch Code:	Billable:
11/19/2024	9	RN10H - RN VISIT + SUP	MCA	X

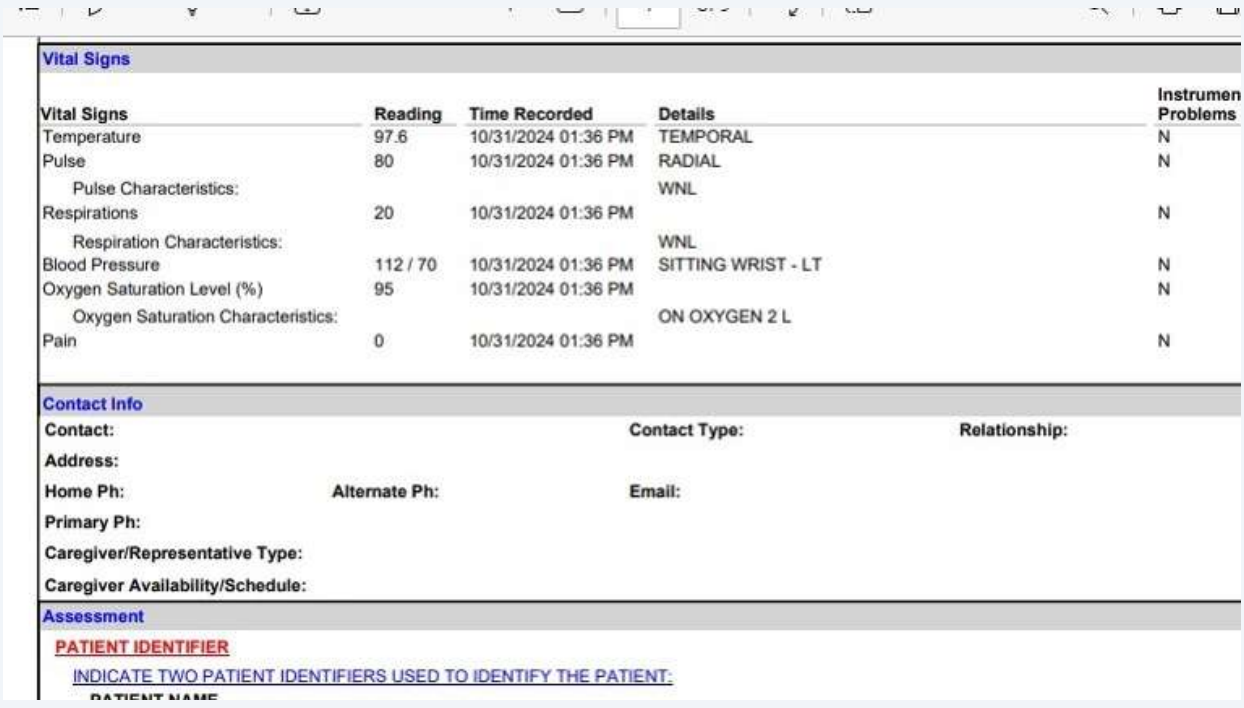
Agent ID:	Agent Name:	Mileage Payment Method:	Trip Fees:	Mileage Start:	Mileage End:	Mileage:
300033	JENNYLYN ANGELES RN	AM	0.00	0	0	0

Time:

TRAVEL TIME	DRIVE START TIME	11/19/2024 11:44 AM	DRIVE END TIME	11/19/2024 11:56 AM
IN-HOME TIME	BEGAN	11/19/2024 11:56 AM	INCOMPLETE	11/19/2024 12:24 PM
DOCUMENTATION TIME	RESUMED	11/19/2024 11:04 PM	COMPLETED	11/19/2024 11:55 PM

Total In-Home Time: 0.46 Hours
Total Drive Time: 0.21 Hours
Total Doc Time: 0.84 Hours

6 The vital signs recorded during that visit.



Vital Signs

Vital Signs	Reading	Time Recorded	Details	Instrumen Problems
Temperature	97.6	10/31/2024 01:36 PM	TEMPORAL	N
Pulse	80	10/31/2024 01:36 PM	RADIAL	N
Pulse Characteristics:			WNL	
Respirations	20	10/31/2024 01:36 PM		N
Respiration Characteristics:			WNL	
Blood Pressure	112 / 70	10/31/2024 01:36 PM	SITTING WRIST - LT	N
Oxygen Saturation Level (%)	95	10/31/2024 01:36 PM		N
Oxygen Saturation Characteristics:			ON OXYGEN 2 L	
Pain	0	10/31/2024 01:36 PM		N

Contact Info

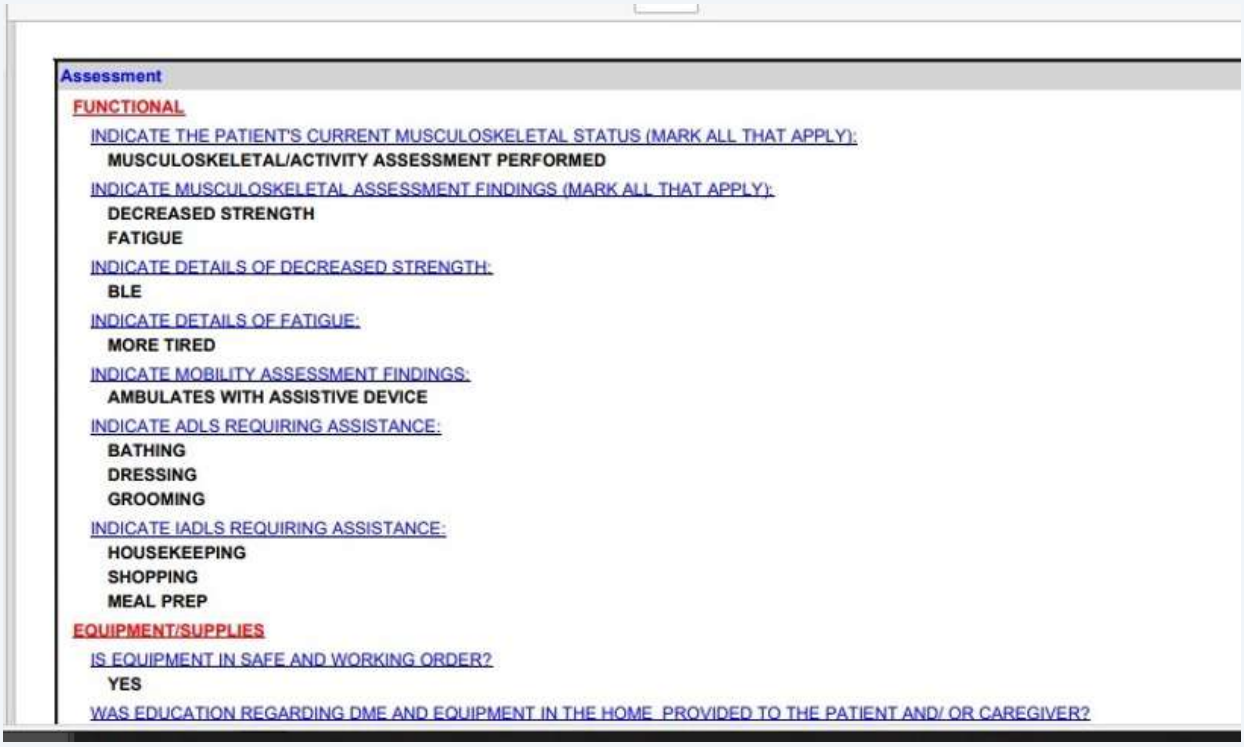
Contact: **Contact Type:** **Relationship:**
Address:
Home Ph: **Alternate Ph:** **Email:**
Primary Ph:
Caregiver/Representative Type:
Caregiver Availability/Schedule:

Assessment

PATIENT IDENTIFIER

INDICATE TWO PATIENT IDENTIFIERS USED TO IDENTIFY THE PATIENT:

7 Assessment findings. These assessments are important as they help track the patient's condition, guide care decisions, and ensure continuity of care across the team.



Assessment

FUNCTIONAL

INDICATE THE PATIENT'S CURRENT MUSCULOSKELETAL STATUS (MARK ALL THAT APPLY):
- **MUSCULOSKELETAL/ACTIVITY ASSESSMENT PERFORMED**

INDICATE MUSCULOSKELETAL ASSESSMENT FINDINGS (MARK ALL THAT APPLY):
- **DECREASED STRENGTH**
- **FATIGUE**

INDICATE DETAILS OF DECREASED STRENGTH:
- **BLE**

INDICATE DETAILS OF FATIGUE:
- **MORE TIRED**

INDICATE MOBILITY ASSESSMENT FINDINGS:
- **AMBULATES WITH ASSISTIVE DEVICE**

INDICATE ADLS REQUIRING ASSISTANCE:
- **BATHING**
- **DRESSING**
- **GROOMING**

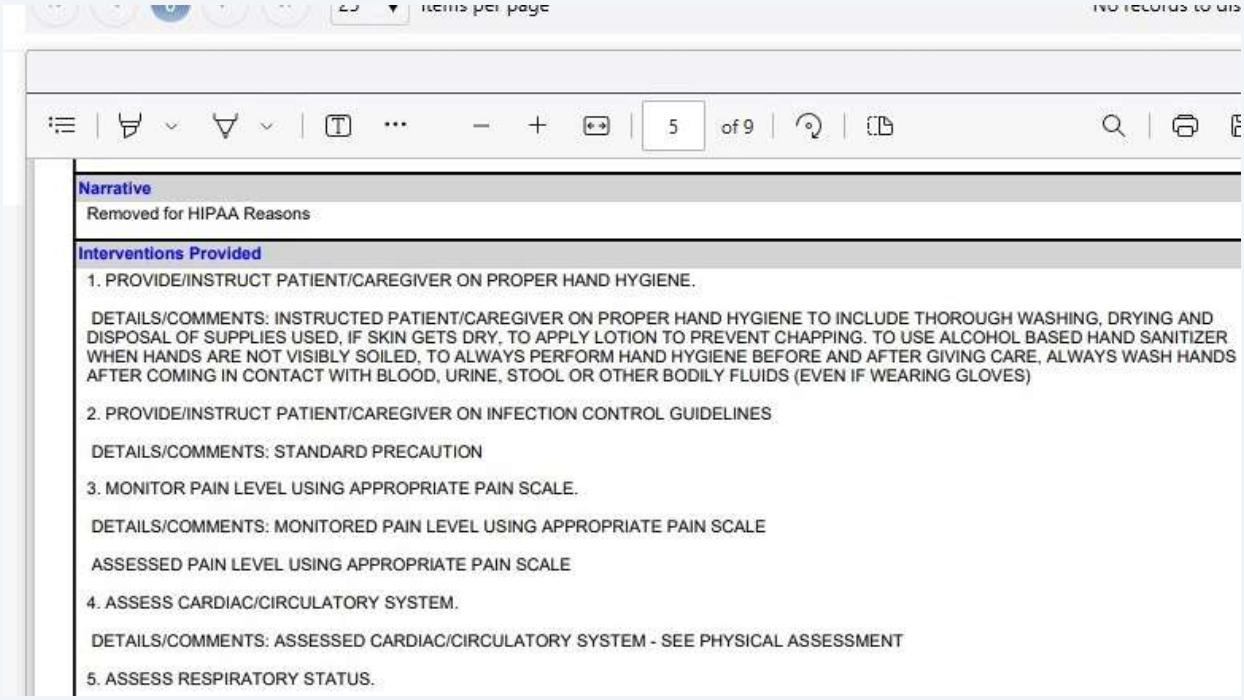
INDICATE IADLS REQUIRING ASSISTANCE:
- **HOUSEKEEPING**
- **SHOPPING**
- **MEAL PREP**

EQUIPMENT/SUPPLIES

IS EQUIPMENT IN SAFE AND WORKING ORDER?
- **YES**

WAS EDUCATION REGARDING DME AND EQUIPMENT IN THE HOME PROVIDED TO THE PATIENT AND/ OR CAREGIVER?

8 Interventions Provided section, which outlines the care and actions taken during the visit. There is a narrative section as well, helping to tell the full story of the patient's status and ensures clarity for the rest of the care team.



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Narrative

Removed for HIPAA Reasons

Interventions Provided

1. PROVIDE/INSTRUCT PATIENT/CAREGIVER ON PROPER HAND HYGIENE.

DETAILS/COMMENTS: INSTRUCTED PATIENT/CAREGIVER ON PROPER HAND HYGIENE TO INCLUDE THOROUGH WASHING, DRYING AND DISPOSAL OF SUPPLIES USED, IF SKIN GETS DRY, TO APPLY LOTION TO PREVENT CHAPPING. TO USE ALCOHOL BASED HAND SANITIZER WHEN HANDS ARE NOT VISIBLY SOILED, TO ALWAYS PERFORM HAND HYGIENE BEFORE AND AFTER GIVING CARE, ALWAYS WASH HANDS AFTER COMING IN CONTACT WITH BLOOD, URINE, STOOL OR OTHER BODILY FLUIDS (EVEN IF WEARING GLOVES)

2. PROVIDE/INSTRUCT PATIENT/CAREGIVER ON INFECTION CONTROL GUIDELINES

DETAILS/COMMENTS: STANDARD PRECAUTION

3. MONITOR PAIN LEVEL USING APPROPRIATE PAIN SCALE.

DETAILS/COMMENTS: MONITORED PAIN LEVEL USING APPROPRIATE PAIN SCALE

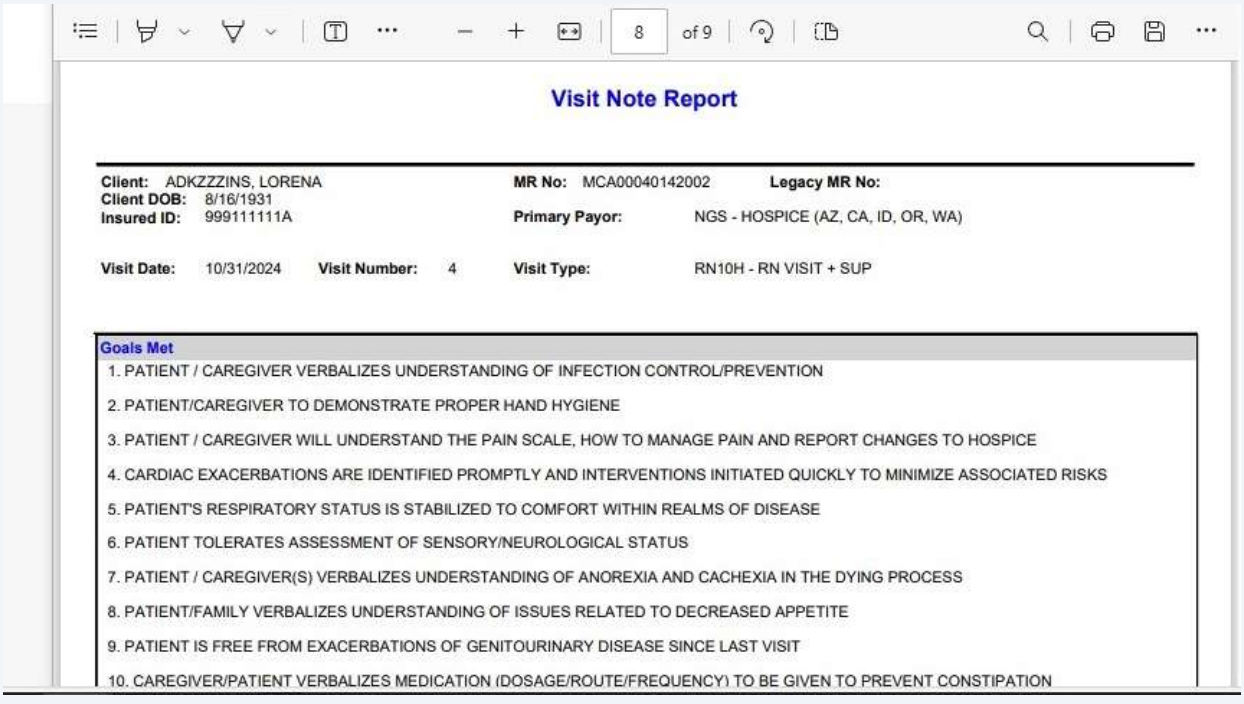
ASSESSED PAIN LEVEL USING APPROPRIATE PAIN SCALE

4. ASSESS CARDIAC/CIRCULATORY SYSTEM.

DETAILS/COMMENTS: ASSESSED CARDIAC/CIRCULATORY SYSTEM - SEE PHYSICAL ASSESSMENT

5. ASSESS RESPIRATORY STATUS.

9 As you can see the visit note report captures vital information. Including goals met and key outcomes supporting quality care, informed decision-making, and effective team communication.



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Insured ID: 999111111A
MR No: MCA00040142002 **Legacy MR No:**
Primary Payor: NGS - HOSPICE (AZ, CA, ID, OR, WA)

Visit Date: 10/31/2024 **Visit Number:** 4 **Visit Type:** RN10H - RN VISIT + SUP

Goals Met

1. PATIENT / CAREGIVER VERBALIZES UNDERSTANDING OF INFECTION CONTROL/PREVENTION
2. PATIENT/CAREGIVER TO DEMONSTRATE PROPER HAND HYGIENE
3. PATIENT / CAREGIVER WILL UNDERSTAND THE PAIN SCALE, HOW TO MANAGE PAIN AND REPORT CHANGES TO HOSPICE
4. CARDIAC EXACERBATIONS ARE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED QUICKLY TO MINIMIZE ASSOCIATED RISKS
5. PATIENT'S RESPIRATORY STATUS IS STABILIZED TO COMFORT WITHIN REALMS OF DISEASE
6. PATIENT TOLERATES ASSESSMENT OF SENSORY/NEUROLOGICAL STATUS
7. PATIENT / CAREGIVER(S) VERBALIZES UNDERSTANDING OF ANOREXIA AND CACHEXIA IN THE DYING PROCESS
8. PATIENT/FAMILY VERBALIZES UNDERSTANDING OF ISSUES RELATED TO DECREASED APPETITE
9. PATIENT IS FREE FROM EXACERBATIONS OF GENITOURINARY DISEASE SINCE LAST VISIT
10. CAREGIVER/PATIENT VERBALIZES MEDICATION (DOSAGE/ROUTE/FREQUENCY) TO BE GIVEN TO PREVENT CONSTIPATION