

SERVICE PLAN & CONTACT RECORD FOLLOW-UP

Patient Name:	Physician's Name:	Physician's Phone:
Diagnosis / Surgery:		Therapy Start Date:

Phone Follow Up Home Follow Up
Date: _____

Phone Follow Up Home Follow Up
Date: _____

Phone Follow Up Home Follow Up
Date: _____

Rx / PROGRESS / INSTRUCTIONS

Current Settings _____

Hrs. used / Day _____

Additional Instructions _____

Patient describes being comfortable while receiving Therapy Yes No

- A. COORDINATION OF SERVICES
Other organization service continued Yes No
- B. ENVIRONMENTAL SAFETY FACTORS
Environment remains suitable Yes No
- C. FUNCTIONAL LIMITATION TO USE
(If applicable)
Satisfactory adaptation for safe equipment operation Yes No
- D. EQUIPMENT OPERATION
Safe equipment operation described Yes No
- E. EQUIPMENT MAINTENANCE
Equipment maintained as directed Yes No
- F. JACE SYSTEMS SERVICE
Service reviewed
Business Hours Yes No
Phone numbers Yes No
Discharge Instructions Yes No

NOTES

JACE Representative Signature:

Rx / PROGRESS / INSTRUCTIONS

Current Settings _____

Hrs. used / Day _____

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