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| --- | --- | --- | --- | --- |
| Shift Date  *MM/DD/YY* | Client Tracking\*  *\*If Required by Care Plan* | Read care plan | Comments  *(Non Routine Events Only)* | Print Name &  Signature |
| Date:  \_\_\_\_\_\_\_\_\_\_  AM PM | Date of last BM:  \_\_\_\_\_\_\_\_\_\_  Blood Pressure:  \_\_\_ /\_\_\_ | I have read the care plan |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  X\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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