NAME: _____ **DATE:**_____

Treatment: NP FC FX LSR LLLSR I/CL CORN N/BRC W/C W/DRS COMPR ORTHO MTH B

Patient Concerns or Health Changes_____

POD. NURSES PROGRESS NOTES/ CARE PLAN

Soak NC/F NDEB HDEB CORN CALLOUS SCALPEL

_____

_____

_____

_____

Extra Care:_____

Products Given in Treatment Room: _____

Nurse's Products Recommended:_____

Freq. of Visits_____

Photos Taken? YES or NO Date:_____

POD. Nurse/ Assistant Signature:_____**Date:**_____

Admin Use Only

PRODUCT PURCHASED:_____

PYMT METHOD: V MC CASH DEBIT CHQ

AMOUNT $: _____**Purchased:** _____

NEXT SCHEDULED VISIT: _____

I/CL= Ionic Cleanse MTH B= Meth Blue Treatment W/C=Wound Care FX LSR=Fungal and Wart removal laser

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Ontario Podortho Nursing Association
ADVANCING • PROMOTING • SUPPORTING