



<b>CLIENT NAME</b> (PLEASE PRINT)								<b>CAREGIVER NAME</b> (PLEASE PRINT)														
	<b>SUN</b>		<b>MON</b>		<b>TUE</b>			<b>WED</b>		<b>THU</b>		<b>FRI</b>		<b>SAT</b>								
<b>DATE</b>																						
<b>TIME IN</b>	am / pm		am / pm		am / pm		am / pm		am / pm		am / pm		am / pm		am / pm							
<b>TIME OUT</b>	am / pm		am / pm		am / pm		am / pm		am / pm		am / pm		am / pm		am / pm							
<b>TIME IN</b>	am / pm		am / pm		am / pm		am / pm		am / pm		am / pm		am / pm		am / pm							
<b>TIME OUT</b>	am / pm		am / pm		am / pm		am / pm		am / pm		am / pm		am / pm		am / pm							
<b>TOTAL</b>																						
<b>OFFICE USE ONLY</b>																						
<b>BATHING / PERSONAL</b>								<b>HOUSEKEEPING</b>														
								Su	Mo	Tu	We	Th	Fr	Sa								
Bath : Sponge, Bed, Tub, Shower								Clean Kitchen														
Peri Care								Clean Bathroom														
Hair : Shampoo, Set, Dry, Comb								Clean Bedroom														
Shaving								Change Linen / Laundry														
Skin Care (note any problem areas)								Dust / Clean														
Nail Care (only if NOT diabetic)								Floor Care : Vacuum, Sweep, Mop														
Oral / Dental Care : Teeth, Dentures								Wash Dishes														
Dress / Undress								Clean Equipment														
Toileting / Chart Daily BMs								Take Out Trash														
Change protective undergarments								<b>TRANSPORTATION</b>														
								Su	Mo	Tu	We	Th	Fr	Sa								
Empty / Clean Urinal, Catheter Bag								Accompany Client to Appt / Errand														
Empty / Clean Colostomy Bag								Errands / Shopping for Client														
Empty / Clean Bedpan, Commode								via Transport Van / Company Car														
Clean Glasses / Hearing Aid								Employee Car (use mileage form)														
Eating: Assist, Feed, Set-up								<b>ACTIVITIES</b>														
Support Hose : ON / OFF								Su	Mo	Tu	We	Th	Fr	Sa								
<b>MEDICATION REMINDER</b>								Range of Motion / Exercises														
								Swimming														
Remind Client to take Medications								Bed Rest														
<b>ASSISTIVE DEVICES</b>								Su	Mo	Tu	We	Th	Fr	Sa	Chair / Couch							
Gait Belt								Reposition 2 hrs or as needed														
Wheelchair								<b>SAFETY PRECAUTIONS</b>														
Walker								Su	Mo	Tu	We	Th	Fr	Sa	Aspiration							
Cane								Fall Risk														
Slideboard								Seizure														
Mechanical Lift / Hoyer Sit-Stand								Transfer per Plan of Care														
Splints / Brace ON / OFF								<b>NOTES</b> (use extra sheet or incident report, as needed)														
<b>RESPIRATORY</b>								Su	Mo	Tu	We	Th	Fr	Sa								
Ventilator																						
Tracheotomy																						
BiPAP / CPAP																						
Oxygen AMT or % :																						
<b>CLIENT SIGNATURE</b>								<b>CAREGIVER SIGNATURE</b>														
<b>CLIENT INITIALS</b>	<b>SUN</b>	<b>MON</b>	<b>TUE</b>	<b>WED</b>	<b>THU</b>	<b>FRI</b>	<b>SAT</b>	<b>Service Month</b>		<b>Service Year</b>												

