***** DUE INTO OFFICE EVERY MONDAY BEFORE NOON! *****

Employee Name: ______________________ Client Name: ______________________

Employee Signature: ______________________
I hereby certify that the above hours are accurate and that I complied with the rules and regulations required by At Home Senior Services.

Client Signature: ______________________
I hereby certify that the above hours worked by At Home Senior Services' Employee represent the true accurate hours for which services were performed.

Date: ______________ **Time In:** ______________ **Time Out:** ______________

Total Hours Worked: ______________ **Clients Initials:** ______________

C = Completed

PERSONAL CARE

- -Bed ______
- -Tub/ Shower ______
- -Assist bathing ______
- -Assist with dressing ______
- -Hair Care ______
- -Skin Care ______
- -Foot Care ______
- -Check Pressure areas ______
- -Shave/ Deodorant ______
- -Nail Hygiene/ Clean/ File ______
- -Oral- Brush/ Dentures ______
- -Elimination Assistance ______

PROCEDURES

- -Incontinent Care ______
- -Record Input/ Output ______
- -Medication reminders ______

INFECTION CONTROL

- -Universal Precaution ______

SAFETY MEASURE

- -Lock w/c ______
- -Bed rails ______
- -Safe Transfer ______
- -Check water Temp ______

ACTIVITY

- -Ambulation/ Assist ______
- -Range of motion ______
- -Transfers ______
- -Turn in bed ______

NUTRITION

- -Meal Preparation ______
- -Assist with Feeding ______
- -Encourage Fluids ______
- -Limit Fluids ______
- -Grocery Shopping ______

HOMEMAKING

- -Light Housekeeping ______
- -Kitchen Duties ______
- -Bedroom ______
- -Bathroom ______
- -Laundry ______
- -Vacuum/ Dust ______
- -Sweep / Mop ______

Mileage: ______________

Destination: ______________

DAILY NOTES/ NARRATIVE: Complete every shift/ continue on back if needed

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