At Home Senior Services

********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.

C = Completed

Clients Initials: _____

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date: *Month / Day / Year*							
Time IN							
Time OUT							
Total Hours							
Client Initials							
Personal Care:							
Bed							
Tub/ Shower							
Assist w/ Bath							
Assist w/Dress							
Hair Care							
Skin Care							
Foot Care							
Nail Care							
Pressure Areas							
Oral Hygiene							
Shave/ Deodorant							
Procedures:							
Incontinent Care							
Record Input/Output							
Medication Reminder							
Infection Control:							
Universal Precaution							

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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 w/Feeding							
Encourage Fluids							
Limit Fluids							
Grocery Shopping							
Homemaking:							
Kitchen Duties							
Bedroom							
Bathroom							
Laundry							
Vacuum /Dust							
Sweep /Mop							
Mileage:							
Destination:							

DAILY NOTES/ NARRATIVE: *Please provide the date of notes recorded.*